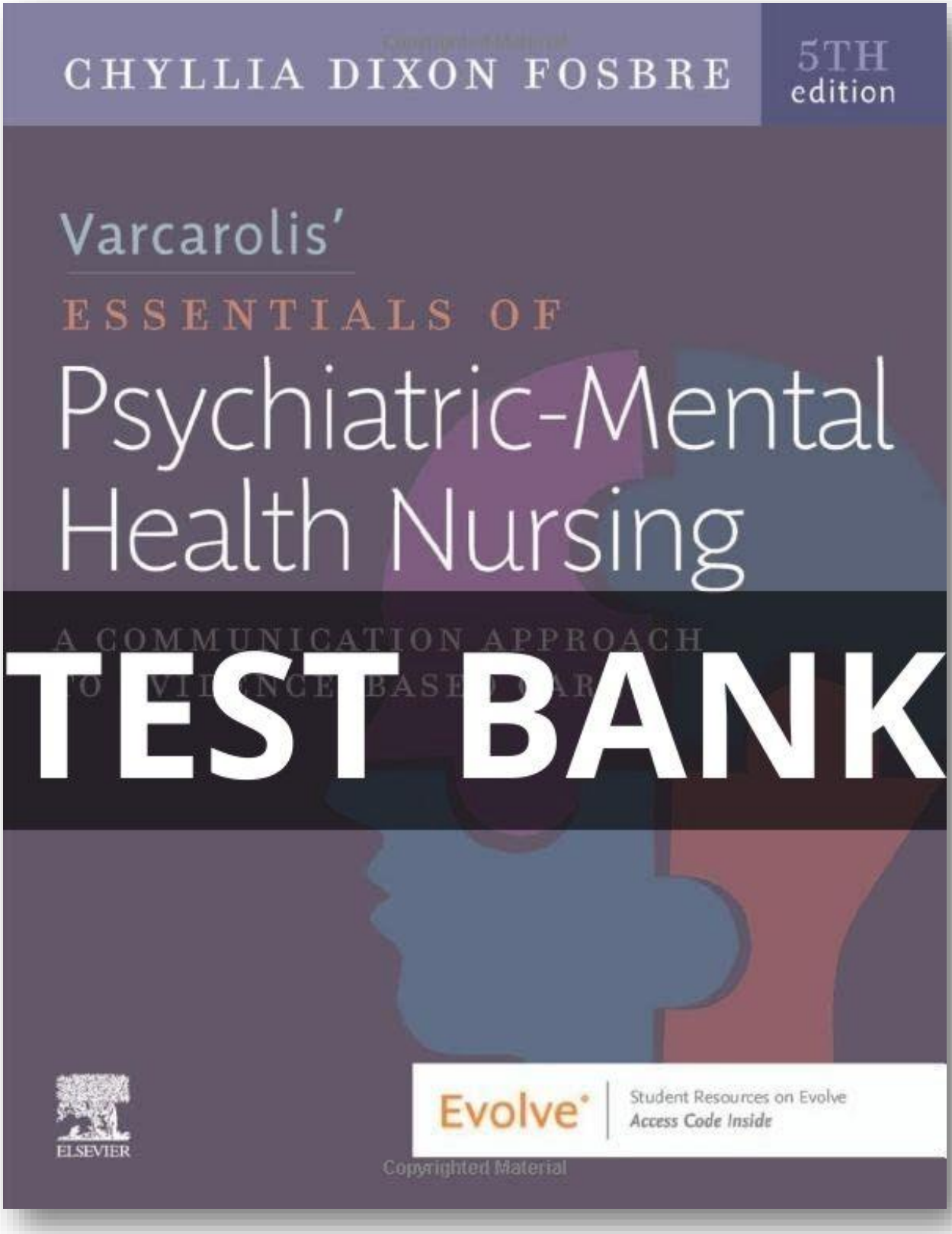
Test Bank

Varcarolis' Essentials of Psychiatric Mental Health Nursing 5th Edition Fosbre



Chapter 01: Science and the Therapeutic Use of Self in Psychiatric Mental Health Nursing
Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 5e

MULTIPLE CHOICE

1. Which outcome, focused on recovery, would be expected in the plan of care for a patient living in the community and diagnosed with serious and persistent mental illness? Within 3 months, the patient will demonstrate what behavior?
   a. Denying suicidal ideation
   b. Reporting a sense of well-being
   c. Taking medications as prescribed
   d. Attending clinic appointments on time

   ANS: B
   Recovery emphasizes managing symptoms, reducing psychosocial disability, and improving role performance. The goal of recovery is to empower the individual with mental illness to achieve a sense of meaning and satisfaction in life and to function at the highest possible level of wellness. The incorrect options focus on the classic medical model rather than recovery.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Outcomes Identification
   MSC: NCLEX: Health Promotion and Maintenance

2. A patient is hospitalized for depression and suicidal ideation after their spouse asks for a divorce. Select the nurse's **most** caring comment.
   a. "Let's discuss healthy means of coping when you have suicidal feelings."
   b. "I understand why you're so depressed. When I got divorced, I was devastated too."
   c. "You should forget about your marriage and move on with your life."
   d. "How did you get so depressed that hospitalization was necessary?"

   ANS: A
   The nurse's communication should evidence caring and a commitment to work with the patient. This commitment lets the patient know the nurse will help. Probing and advice are not helpful for therapeutic interventions.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

3. In the shift-change report, an off-going nurse criticizes a patient who wears extremely heavy makeup. Which comment by the nurse who receives the report best demonstrates advocacy?
   a. "This is a psychiatric hospital, so we expect our patients to behave bizarrely."
   b. "Let's all show acceptance of this patient by wearing lots of makeup too."
   c. "Your comments are inconsiderate and inappropriate. Keep the report objective."
   d. "Our patients need our help to learn behaviors that will help them get along in society."

   ANS: D

Accepting patients' needs for self-expression and seeking to teach skills that will contribute to their well-being demonstrate respect and are important parts of advocacy. The on-coming nurse needs to take action to ensure that others are not prejudiced against the patient. Humor can be appropriate within the privacy of a shift report but not at the expense of respect for patients. Judging the off-going nurse in a critical way will create conflict. Nurses must show compassion for each other.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

4. A nurse assesses a newly admitted patient diagnosed with major depressive disorder. Which statement is an example of "attending"?
   a. "We all have stress in life. Being in a psychiatric hospital is not the end of the world."
   b. "Tell me why you felt you had to be hospitalized to receive treatment for your depression."
   c. "You will feel better after we get some antidepressant medication started for you."
   d. "I'd like to sit with you for a while, so you may feel more comfortable talking with me."

   ANS: D
   Attending is a technique that demonstrates the nurse's commitment to the relationship and reduces feelings of isolation. This technique shows respect for the patient and demonstrates caring. Generalizations, probing, and false reassurances are nontherapeutic.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

5. A patient shows the nurse an article from the Internet about a health problem. Which characteristic of the website's address most alerts the nurse that the site may have biased and prejudiced information?
   a. Address ends in ".org."
   b. Address ends in ".com."
   c. Address ends in ".gov."
   d. Address ends in ".net."

   ANS: B
   Financial influences on a site are a clue that the information may be biased. ".com" at the end of the address indicates that the site is a commercial one. ".gov" indicates that the site is maintained by a government entity. ".org" indicates that the site is nonproprietary; the site may or may not have reliable information, but it does not profit from its activities. ".net" can have multiple meanings.

   DIF: Cognitive Level: Comprehension (Understanding) TOP: Nursing Process: Evaluation
   MSC: NCLEX: Health Promotion and Maintenance

6. A nurse says, "When I was in school, I learned to call upset patients by name to get their attention; however, I read a descriptive research study that says that this approach does not work. I plan to stop calling patients by name." Which statement is the best appraisal of this nurse's comment?
   a. One descriptive research study rarely provides enough evidence to change practice.
   b. Staff nurses apply new research findings only with the help from clinical nurse specialists.

c. New research findings should be incorporated into clinical algorithms before using them in practice.
d. The nurse misinterpreted the results of the study. Classic tenets of practice do not change.

ANS: A
Descriptive research findings provide evidence for practice but must be viewed in relation to other studies before practice changes. One study is not enough. Descriptive studies are low on the hierarchy of evidence. Clinical algorithms use flowcharts to manage problems and do not specify one response to a clinical problem. Classic tenets of practice should change as research findings provide evidence for change.

DIF: Cognitive Level: Analysis (Analyzing) TOP: Nursing Process: Evaluation
MSC: NCLEX: Health Promotion and Maintenance

7. Two nursing students discuss career plans after graduation. One student wants to enter psychiatric nursing. The other student asks, "Why would you want to be a psychiatric nurse? All they do is talk. You will lose your skills." Select the best response by the student interested in psychiatric nursing.
   a. "Psychiatric nurses' practice in safer environments than other specialties and nurse-to-patient ratios are better because of the nature of patients' problems."
   b. "Psychiatric nurses use complex communication skills, as well as critical thinking, to solve multidimensional problems. I'm challenged by those situations."
   c. "I think I will be good in the mental health field. I do not like clinical rotations in school, so I do not want to continue them after I graduate."
   d. "Psychiatric nurses do not have to deal with as much pain and suffering as medical-surgical nurses. That appeals to me."

   ANS: B
   The practice of psychiatric nursing requires a different set of skills than medical-surgical nursing, although substantial overlap does exist. Psychiatric nurses must be able to help patients with medical and mental health problems, reflecting the holistic perspective these nurses must have. Nurse–patient ratios and workloads in psychiatric settings have increased, similar to other specialties. Psychiatric nursing involves clinical practice, not simply documentation. Psychosocial pain is real and can cause as much suffering as physical pain.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

8. Which research evidence would most influence a group of nurses to change their practice?
   a. Expert committee report of recommendations for practice
   b. Systematic review of randomized controlled trials
   c. Nonexperimental descriptive study
   d. Critical pathway

   ANS: B
   Research findings are graded using a hierarchy of evidence. A systematic review of randomized controlled trials is level A and provides the strongest evidence for changing practice. Expert committee recommendations and descriptive studies lend less powerful and influential evidence. A critical pathway is not evidence; it incorporates research findings after they have been analyzed.

DIF: Cognitive Level: Comprehension (Understanding) TOP: Nursing Process: Planning
MSC: NCLEX: Safe, Effective Care Environment

9. A bill introduced in Congress would reduce funding for the care of people diagnosed with mental illnesses. A group of nurses write letters to their elected representatives in opposition to the legislation. Which role have the nurses fulfilled?
   a. Advocacy
   b. Attending
   c. Recovery
   d. Evidence-based practice

   ANS: A
   An advocate defends or asserts another's cause, particularly when the other person lacks the ability to do that for him or herself. Examples of individual advocacy include helping patients understand their rights or make decisions. On a community scale, advocacy includes political activity, public speaking, and publication in the interest of improving the individuals with mental illness; the letter-writing campaign advocates for that cause on behalf of patients who are unable to articulate their own needs.

   DIF: Cognitive Level: Comprehension (Understanding)
   TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

10. An informal group of patients discuss their perceptions of nursing care. Which comment best indicates a patient's perception that his or her nurse is caring?
    a. "My nurse always asks me which type of juice I want to help me swallow my medication."
    b. "My nurse explained my treatment plan to me and asked for my ideas about how to make it better."
    c. "My nurse told me that if I take all the medicines the doctor prescribes, I will get discharged soon."
    d. "My nurse spends time listening to me talk about my problems. That helps me feel like I'm not alone."

    ANS: D
    Caring evidences empathic understanding as well as competency. It helps change pain and suffering into a shared experience, creating a human connection that alleviates feelings of isolation. The incorrect options give examples of statements that demonstrate advocacy or giving advice.

    DIF: Cognitive Level: Application (Applying) TOP: Nursing Process: Evaluation
    MSC: NCLEX: Psychosocial Integrity

11. A patient who immigrated to the United States from Honduras was diagnosed with schizophrenia. The patient took an antipsychotic medication for 3 weeks but showed no improvement. Which resource should the treatment team consult for information on more effective medications for this patient?
    a. Clinical algorithm
    b. Clinical pathway
    c. Clinical practice guideline
    d. *International Statistical Classification of Diseases and Related Health Problems* (ICD)

    ANS: A

A clinical algorithm is a guideline that describes diagnostic and/or treatment approaches drawn from large databases of information. These guidelines help the treatment team make decisions cognizant of an individual patient's needs, such as ethnic origin, age, or gender. A clinical pathway is a map of interventions and treatments related to a specific disorder. Clinical practice guidelines summarize best practices about specific health problems. The ICD classifies diseases.

DIF: Cognitive Level: Application (Applying) TOP: Nursing Process: Evaluation
MSC: NCLEX: Safe, Effective Care Environment

12. A team of nurses wants to integrate evidence-based practice into a facility's clinical pathways. Which step should the team implement first?
    a. Acquire findings from published literature.
    b. Apply the research findings to clinical practice.
    c. Assess the outcomes of using new research findings.
    d. Ask questions to identify clinical problems that should be changed.

ANS: D
Integrating evidence-based practice is a multistep process rather than a single change event. The first step is to identify clinical problems that should be changed. Each step must proceed in order when integrated into a clinical environment.

DIF: Cognitive Level: Application (Applying) TOP: Nursing Process: Planning
MSC: NCLEX: Safe, Effective Care Environment

13. A nurse consistently strives to demonstrate caring behaviors during interactions with patients. Which reaction reported by a patient indicates this nurse is most effective?
    a. Feeling less distrustful of others
    b. Sensing a connection with others
    c. Experiencing only minimal uneasiness about the future
    d. Being somewhat encouraged with efforts to improve

ANS: B
A patient is likely to respond most to caring with a sense of connectedness with others. The absence of caring can make patients feel some degree of distrustful, disconnection, unease, and discouragement.

DIF: Cognitive Level: Comprehension (Understanding) TOP: Nursing Process: Evaluation
MSC: NCLEX: Psychosocial Integrity

MULTIPLE RESPONSE

1. An experienced nurse says to a new graduate, "When you've practiced as long as I have, you will instantly know how to take care of psychotic patients." What is the new graduate's best analysis of this comment? (*Select all that apply.*)
    a. The experienced nurse may have lost sight of patients' individuality, which may compromise the integrity of practice.
    b. New research findings must be continually integrated into a nurse's practice to provide the most effective care.
    c. Experience provides mental health nurses with the tools and skills needed for effective professional practice.

d. Experienced psychiatric nurses have learned the best ways to care for psychotic patients through trial and error.
e. Effective psychiatric nurses should be continually guided by an intuitive sense of patients' needs.

ANS: A, B
Evidence-based practice involves using research findings to provide the most effective nursing care. Evidence is continually emerging; therefore, nurses cannot rely solely on experience. The effective nurse also maintains respect for each patient as an individual. Overgeneralization compromises that perspective. Intuition and trial and error are unsystematic approaches to care.

DIF: Cognitive Level: Application (Applying) TOP: Nursing Process: Evaluation
MSC: NCLEX: Safe, Effective Care Environment

2. Which patient statements identify qualities of nursing practice with high therapeutic value? "My nurse: (*Select all that apply*.)
   a. "The nurses talk in language I can understand."
   b. "The nursing staff helps me keep track of my medications."
   c. "My nurse is willing to go to social activities with me."
   d. "The staff lets me do whatever I choose without interfering."
   e. "My nurses look at me as a whole person with different needs."

   ANS: A, B, E
   Each correct answer demonstrates caring is an example of appropriate nursing foci: communicating at a level understandable to the patient, using holistic principles to guide care, and providing medication supervision. The incorrect options suggest a laissez-faire attitude on the part of the nurse when the nurse should instead provide thoughtful feedback and help patients test alternative solutions or violate boundaries.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

Chapter 02: Mental Health and Mental Illness
Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 5e

MULTIPLE CHOICE

1. An 86 year old, previously healthy and independent, falls after an episode of vertigo. Which statement made by this patient best demonstrates resilience?
   a. "I knew this would happen eventually."
   b. "Attending my weekly water aerobics class is too risky."
   c. "I don't need that silly walker to get around by myself."
   d. "Maybe some physical therapy will help me with my balance."

   ANS: D

Resiliency is the ability to recover from or adjust to misfortune and change. The correct response indicates that the patient is hopeful and thinking positively about ways to adapt to the vertigo. Saying "I knew this would happen eventually" and discontinuing healthy activities suggest a hopeless perspective on the health change. Refusing to use a walker indicates denial.

DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

2. Which basic intervention should a psychiatric mental health nurse plan to provide for a patient diagnosed with a mood disorder?
   a. Sharing clinical expertise to enhance patient treatment
   b. Performing individual or group psychotherapy for the patient
   c. Using appropriate diagnostic tests to monitor patient condition
   d. Conducting stress reduction and health maintenance classes

   ANS: D
   Conducting stress reduction and health maintenance classes is the basic intervention that should be performed by a psychiatric mental health nurse. These classes will provide individualized guidance to patients to prevent or reduce mental illness and improve mental health. Community screenings and stress management classes are examples of health maintenance classes. Consulting nurses from other disciplines to share clinical expertise and enhance patient treatment is an advanced practice psychiatric mental health nursing intervention. Performing individual and group psychotherapy and performing diagnostic tests like blood pressure, etc., are also advanced practice psychiatric mental health nursing interventions.

   DIF: Cognitive Level: Application (Applying) TOP: Nursing Process: Planning
   MSC: NCLEX: Psychosocial Integrity

3. A patient is admitted to the psychiatric hospital. Which assessment finding best indicates that the patient has a mental illness? The patient:
   a. describes coping and relaxation strategies used when feeling anxious.
   b. describes mood as consistently sad, discouraged, and hopeless.
   c. can perform tasks attempted within the limits of own abilities.
   d. reports occasional problems with insomnia.

   ANS: B
   A patient who reports having a consistently negative mood is describing a mood alteration that affects the ability to function optimistically. The incorrect options describe mentally healthy behaviors and common problems that do not indicate mental illness.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

4. The goal for a patient is to increase resiliency. Which outcome should a nurse add to the plan of care to be achieved within 3 days?
   a. Patient describes feelings associated with loss and stress.
   b. Patient meet own needs before considering the rights of others.
   c. Patient will identify healthy coping behaviors in response to stressful events.
   d. Patient will allow others to assume responsibility for major areas of own life.

ANS: C
The patient's ability to identify healthy coping behaviors indicates adaptive, healthy behavior and demonstrates an increased ability to recover from severe stress. Describing feelings associated with loss and stress does not move the patient toward adaptation. The remaining options are maladaptive behaviors.

DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Outcomes Identification
MSC: NCLEX: Psychosocial Integrity

5. A nurse at a behavioral health clinic sees an unfamiliar psychiatric diagnosis on a patient's insurance form. Which resource should the nurse consult to discern the criteria used to establish this diagnosis?
   a. A psychiatric nursing textbook
   b. *NANDA International (NANDA-I)*
   c. A behavioral health reference manual
   d. *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*)

   ANS: D
   The *DSM-5* gives the criteria used to diagnose each mental disorder. The *NANDA-I* focuses on nursing diagnoses. A psychiatric nursing textbook or behavioral health reference manual may not contain diagnostic criteria.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Analysis | Nursing Process: Diagnosis
   MSC: NCLEX: Safe, Effective Care Environment

6. A nurse must assess several new patients at a community mental health center. Conclusions concerning current functioning should be made on the basis of what factor?
   a. The degree of conformity of the individual to society's norms.
   b. The degree to which an individual appears logical and rational.
   c. A continuum from mentally healthy to mentally unhealthy.
   d. The rate of their intellectual and emotional growth.

   ANS: C
   Because mental health and mental illness are relative concepts, assessment of functioning is made by using a continuum. Mental health is not based on conformity; some mentally healthy individuals do not conform to society's norms. Most individuals occasionally display illogical or irrational thinking. The rate of intellectual and emotional growth is not the most useful criterion to assess mental health or mental illness.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Diagnosis | Nursing Process: Analysis
   MSC: NCLEX: Psychosocial Integrity

7. A 40-year-old adult living with parents' states, "I'm happy but I don't socialize much. My work is routine. When new things come up, my boss explains them a few times to make sure I understand. At home, my parents make decisions for me, and I go along with them." A nurse should identify interventions to improve which patient characteristic?
   a. Self-concept
   b. Overall happiness

c. Appraisal of reality
d. Control over behavior

ANS: A
The patient feels the need for multiple explanations of new tasks at work and, despite being 40 years of age, allows both parents to make all decisions. These behaviors indicate a poorly developed self-concept. Although the patient reports being happy, the subsequent comments refute that self-appraisal. The patient's comments do not indicate that he/she is out of touch with reality. The patient's needs are broader than control over own behavior.

DIF: Cognitive Level: Application (Applying) TOP: Nursing Process: Planning
MSC: NCLEX: Psychosocial Integrity

8. A patient tells a nurse, "I have psychiatric problems and am in and out of hospitals all the time. Not one of my friends or relatives has these problems." What is the nurse's best response?
   a. "Comparing yourself with others has no real advantages."
   b. "Why do you blame yourself for having a psychiatric illness?"
   c. "Mental illness affects 50% of the adult population in any given year."
   d. "Are you are concerned that others don't experience the same challenges as you."

   ANS: D
   Mental illness affects many people at various times in their lives. No class, culture, or creed is immune to the challenges of mental illness. The correct response also demonstrates the use of reflection, a therapeutic communication technique. It is not true that mental illness affects 50% of the population in any given year. Asking patients if they blame themselves is an example of probing.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

9. A critical care nurse asks a psychiatric nurse about the difference between a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) and a nursing diagnosis. What is the psychiatric nurse's best response?
   a. "No functional difference exists between the two diagnoses. Both serve to identify a human deviance."
   b. "The *DSM-5* diagnosis disregards culture, whereas the nursing diagnosis includes cultural variables."
   c. "The *DSM-5* diagnosis profiles present distress or disability, whereas a nursing diagnosis considers past and present responses to actual mental health problems."
   d. "The *DSM-5* diagnosis influences the medical treatment; the nursing diagnosis offers a framework to identify interventions for problems a patient has or may experience."

   ANS: D
   The medical diagnosis, defined according to the *DSM-5*, is concerned with the patient's disease state, causes, and cures, whereas the nursing diagnosis focuses on the patient's response to stress and possible caring interventions. Both the *DSM-5* and a nursing diagnosis consider culture. Nursing diagnoses also consider potential problems.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment