

Chapter 1. Mental Health and Mental Illness

Multiple Choice

1. A nurse is assessing a client who is experiencing occasional feelings of sadness because of the recent death of a beloved pet. The clients appetite, sleep patterns, and daily routine have not changed. How should the nurse interpret the clients behaviors?

1. The clients behaviors demonstrate mental illness in the form of depression.
2. The clients behaviors are extensive, which indicates the presence of mental illness.
3. The clients behaviors are not congruent with cultural norms.
4. The clients behaviors demonstrate no functional impairment, indicating no mental illness.

ANS: 4

Rationale: The nurse should assess that the clients daily functioning is not impaired. The client who experiences feelings of sadness after the loss of a pet is responding within normal expectations. Without significant impairment, the clients distress does not indicate a mental illness.

Cognitive Level: Analysis

Integrated Process: Assessment

2. At what point should the nurse determine that a client is at risk for developing a mental illness?

1. When thoughts, feelings, and behaviors are not reflective of the DSM-5 criteria.
2. When maladaptive responses to stress are coupled with interference in daily functioning.
3. When a client communicates significant distress.
4. When a client uses defense mechanisms as ego protection.

ANS: 2

Rationale: The nurse should determine that the client is at risk for mental illness when responses to stress are maladaptive and interfere with daily functioning. The DSM-5 indicates that in order to be diagnosed with a mental illness, daily functioning must be significantly impaired. The clients ability to communicate distress would be considered a positive attribute.

Cognitive Level: Application

Integrated Process: Assessment

3. A nurse is assessing a set of 15-year-old identical twins who respond very differently to stress. One twin becomes anxious and irritable, and the other withdraws and cries. How should the nurse explain these different stress responses to the parents?

1. Reactions to stress are relative rather than absolute; individual responses to stress vary.
2. It is abnormal for identical twins to react differently to similar stressors.
3. Identical twins should share the same temperament and respond similarly to stress.
4. Environmental influences to stress weigh more heavily than genetic influences.

ANS: 1

Rationale: The nurse should explain to the parents that, although the twins have identical DNA, there are several other factors that affect reactions to stress. Mental health is a state of being that is relative to the individual client. Environmental influences and temperament can affect stress reactions.

Cognitive Level: Application

Integrated Process: Implementation

4. Which client should the nurse anticipate to be most receptive to psychiatric treatment?

1. A Jewish, female social worker.
2. A Baptist, homeless male.
3. A Catholic, black male.
4. A Protestant, Swedish business executive.

ANS: 1

Rationale: The nurse should anticipate that the client of Jewish culture would place a high importance on preventative health care and would consider mental health as equally important as physical health. Women are also more likely to seek treatment for mental health problems than men.

Cognitive Level: Application

Integrated Process: Planning

5. A psychiatric nurse intern states, This clients use of defense mechanisms should be eliminated. Which is a correct evaluation of this nurses statement?

1. Defense mechanisms can be appropriate responses to stress and need not be eliminated.
2. Defense mechanisms are a maladaptive attempt of the ego to manage anxiety and should always be eliminated.
3. Defense mechanisms, used by individuals with weak ego integrity, should be discouraged and not eliminated.
4. Defense mechanisms cause disintegration of the ego and should be fostered and encouraged.

ANS: 1

Rationale: The nurse should determine that defense mechanisms can be appropriate during times of stress. The client with no defense mechanisms may have a lower tolerance for stress, thus leading to anxiety disorders. Defense mechanisms should be confronted when they impede the client from developing healthy coping skills.

Cognitive Level: Application

Integrated Process: Evaluation

6. During an intake assessment, a nurse asks both physiological and psychosocial questions. The client angrily responds, Im here for my heart, not my head problems. Which is the nurses best response?

1. Its just a routine part of our assessment. All clients are asked these same questions.
2. Why are you concerned about these types of questions?
3. Psychological factors, like excessive stress, have been found to affect medical conditions.
4. We can skip these questions, if you like. It isnt imperative that we complete this section.

ANS: 3

Rationale: The nurse should attempt to educate the client on the negative effects of excessive stress on medical conditions. It is not appropriate to skip physiological and psychosocial questions, as this would lead to an inaccurate assessment.

Cognitive Level: Application

Integrated Process: Implementation

7. An employee uses the defense mechanism of displacement when the boss openly disagrees with suggestions. What behavior would be expected from this employee?

1. The employee assertively confronts the boss.
2. The employee leaves the staff meeting to work out in the gym.
3. The employee criticizes a coworker.
4. The employee takes the boss out to lunch.

ANS: 3

Rationale: The nurse should expect that the client using the defense mechanism displacement would criticize a coworker after being confronted by the boss. Displacement refers to transferring feelings from one target to a neutral or less-threatening target.

Cognitive Level: Analysis

Integrated Process: Assessment

8. A fourth-grade boy teases and makes jokes about a cute girl in his class. This behavior should be identified by a nurse as indicative of which defense mechanism?

1. Displacement
2. Projection
3. Reaction formation
4. Sublimation

ANS: 3

Rationale: The nurse should identify that the boy is using reaction formation as a defense mechanism. Reaction formation is the attempt to prevent undesirable thoughts from being expressed by expressing opposite thoughts or behaviors. Displacement refers to transferring feelings from one target to another. Rationalization refers to making excuses to justify behavior. Projection refers to the attribution of unacceptable feelings or behaviors to another person. Sublimation refers to channeling unacceptable drives or impulses into more constructive, acceptable activities.

Cognitive Level: Application

Integrated Process: Assessment

9. Which nursing statement about the concept of neurosis is most accurate?

1. An individual experiencing neurosis is unaware that he or she is experiencing distress.
2. An individual experiencing neurosis feels helpless to change his or her situation.
3. An individual experiencing neurosis is aware of psychological causes of his or her behavior.
4. An individual experiencing neurosis has a loss of contact with reality.

ANS: 2

Rationale: The nurse should define the concept of neurosis with the following characteristics:

The client feels helpless to change his or her situation, the client is aware that he or she is experiencing distress, the client is aware the behaviors are maladaptive, the client is unaware of the psychological causes of the distress, and the client experiences no loss of contact with reality.

Cognitive Level: Application
Integrated Process: Assessment

10. Which nursing statement regarding the concept of psychosis is most accurate?

1. Individuals experiencing psychoses are aware that their behaviors are maladaptive.
2. Individuals experiencing psychoses experience little distress.
3. Individuals experiencing psychoses are aware of experiencing psychological problems.
4. Individuals experiencing psychoses are based in reality.

ANS: 2

Rationale: The nurse should understand that the client with psychosis experiences little distress owing to his or her lack of awareness of reality. The client with psychosis is unaware that his or her behavior is maladaptive or that he or she has a psychological problem.

Cognitive Level: Application
Integrated Process: Assessment

11. When under stress, a client routinely uses alcohol to excess. Finding her drunk, her husband yells at the client about her chronic alcohol abuse. Which action alerts the nurse to the clients use of the defense mechanism of denial?

1. The client hides liquor bottles in a closet.
2. The client yells at her son for slouching in his chair.
3. The client burns dinner on purpose.
4. The client says to the spouse, I dont drink too much!

ANS: 4

Rationale: The clients statement I dont drink too much! alerts the nurse to the use of the defense mechanism of denial. The client is refusing to acknowledge the existence of a real situation and the feelings associated with it.

Cognitive Level: Application
Integrated Process: Assessment

12. Devastated by a divorce from an abusive husband, a wife completes grief counseling. Which statement by the wife should indicate to a nurse that the client is in the acceptance stage of grief?

1. If only we could have tried again, things might have worked out.
2. I am so mad that the children and I had to put up with him as long as we did.
3. Yes, it was a difficult relationship, but I think I have learned from the experience.
4. I still dont have any appetite and continue to lose weight.

ANS: 3

Rationale: The nurse should evaluate that the client is in the acceptance stage of grief because during this stage of the grief process, the client would be able to focus on the reality of the loss and its meaning in relation to life.

Cognitive Level: Analysis
Integrated Process: Evaluation

13. A nurse is performing a mental health assessment on an adult client. According to Maslows hierarchy of needs, which client action would demonstrate the highest achievement in terms of mental health? 1. Maintaining a long-term, faithful, intimate relationship. 2. Achieving a sense of self-confidence. 3. Possessing a feeling of self-fulfillment and realizing full potential. 4. Developing a sense of purpose and the ability to direct activities.

ANS: 3

Rationale: The nurse should identify that the client who possesses a feeling of self-fulfillment and realizes his or her full potential has achieved self-actualization, the highest level on Maslows hierarchy of needs.

Cognitive Level: Application
Integrated Process: Assessment

14. According to Maslows hierarchy of needs, which situation on an in-patient psychiatric unit would require priority intervention by a nurse? 1. A client rudely complaining about limited visiting hours. 2. A client exhibiting aggressive behavior toward another client. 3. A client stating that no one cares. 4. A client verbalizing feelings of failure.

ANS: 2

Rationale: The nurse should immediately intervene when a client exhibits aggressive behavior toward another client. Safety and security are considered lower-level needs according to Maslows hierarchy of needs and must be fulfilled before other higher-level needs can be met. Clients who complain, have feelings of failure, or state that no one cares are struggling with higher-level needs such as the need for love and belonging or the need for self-esteem.

Cognitive Level: Analysis
Integrated Process: Evaluation

15. How would a nurse best complete the new DSM-5 definition of a mental disorder? A health condition characterized by significant dysfunction in an individuals cognitions, or behaviors that reflects a disturbance in the

1. psychosocial, biological, or developmental process underlying mental functioning.
2. psychological, cognitive, or developmental process underlying mental functioning.
3. psychological, biological, or developmental process underlying mental functioning.
4. psychological, biological, or psychosocial process underlying mental functioning.

ANS: 3

Rationale: A health condition characterized by significant dysfunction in an individuals cognitions, or behaviors that reflects a disturbance in the psychological, biological, or developmental process underlying mental functioning, is the new DSM 5 definition of a mental disorder.

Cognitive Level: Application
Integrated Process: Assessment

Multiple Response

16. A nurse is assessing a client who appears to be experiencing some anxiety during questioning. Which symptoms might the client demonstrate that would indicate anxiety? (Select all that apply.)

1. Fidgeting
2. Laughing inappropriately
3. Palpitations
4. Nail biting
5. Limited attention span

ANS: 1, 2, 4

Rationale: The nurse should assess that fidgeting, laughing inappropriately, and nail biting are indicative of heightened stress levels. The client would not be diagnosed with mental illness unless there is significant impairment in other areas of daily functioning. Other indicators of more serious anxiety are restlessness, difficulty concentrating, muscle tension, and sleep disturbance.

Cognitive Level: Application

Integrated Process: Assessment

Fill-in-the-Blank

17. _____ is a diffuse apprehension that is vague in nature and is associated with feelings of uncertainty and helplessness.

ANS: Anxiety

Rationale: The definition of anxiety is a diffuse apprehension that is vague in nature and is associated with feelings of uncertainty and helplessness. Townsend considers this a core concept.

Cognitive Level: Application

Integrated Process: Assessment

18. _____ is a subjective state of emotional, physical, and social responses to the loss of a valued entity.

ANS: Grief

Rationale: The definition of grief is a subjective state of emotional, physical, and social responses to the loss of a valued entity. Townsend considers this a core concept.



Chapter 2. Biological Implications

Multiple Choice

1. A depressed client states, I have a chemical imbalance in my brain. I have no control over my behavior. Medications are my only hope to feel normal again. Which nursing response is appropriate? 1. Medications only address biological factors. Environmental and interpersonal factors must also be considered. 2. Because biological factors are the sole cause of depression, medications will improve your mood. 3. Environmental factors have been shown to exert the most influence in the development of depression. 4. Researchers have been unable to demonstrate

a link between nature (biology and genetics) and nurture (environment).

ANS: 1

Rationale: The nurse should advise the client that medications address biological factors, but there are other factors that affect mood. The nurse should educate the client on environmental and interpersonal factors that can lead to depression.

Cognitive Level: Analysis

Integrated Process: Implementation

2. A client diagnosed with major depressive disorder asks, What part of my brain controls my emotions? Which nursing response is appropriate? 1. The occipital lobe governs perceptions, judging them as positive or negative. 2. The parietal lobe has been linked to depression. 3. The medulla regulates key biological and psychological activities. 4. The limbic system is largely responsible for one's emotional state.

ANS: 4

Rationale: The nurse should explain to the client that the limbic system is largely responsible for one's emotional state. This system is often called the emotional brain and is associated with feelings, sexuality, and social behavior. The occipital lobes are the area of visual reception and interpretation. Somatosensory input (touch, taste, temperature, etc.) occurs in the parietal lobes. The medulla contains vital centers that regulate heart rate and reflexes.

Cognitive Level: Application

Integrated Process: Implementation

3. Which part of the nervous system should a nurse identify as playing a major role during stressful situations?

1. Peripheral nervous system 2. Somatic nervous system 3. Sympathetic nervous system 4.

Parasympathetic nervous system

ANS: 3

Rationale: The nurse should identify that the sympathetic nervous system plays a major role during stressful situations. The sympathetic nervous system prepares the body for the fight-or-flight response. The parasympathetic nervous system is dominant when an individual is in a nonstressful state.

Cognitive Level: Comprehension

Integrated Process: Assessment

4. Which client statement reflects an understanding of circadian rhythms in psychopathology? 1. When I dream about my mother's horrible train accident, I become hysterical. 2. I get really irritable during my menstrual cycle. 3. I'm a morning person. I get my best work done before noon.

4. Every February, I tend to experience periods of sadness.

ANS: 3

Rationale: By stating, I am a morning person, the client demonstrates an understanding that circadian rhythms may influence a variety of regulatory functions, including the sleep-wake cycle, regulation of body temperature, and patterns of activity. Most humans follow a 24-hour cycle that is largely affected by lightness and darkness.

Cognitive Level: Analysis

Integrated Process: Evaluation

5. Which types of adoption studies should a nurse recognize as providing useful information for the psychiatric community? 1. Studies in which children with mentally ill biological parents are raised by adoptive parents who were mentally healthy. 2. Studies in which children with mentally healthy biological parents are raised by adoptive parents who were mentally ill. 3. Studies in which monozygotic twins from mentally ill parents were raised separately by different adoptive parents. 4. Studies in which monozygotic twins were raised together by mentally ill biological parents. 5. All of the above.

ANS: 5

Rationale: The nurse should determine that all of the studies could possibly benefit the psychiatric community. The studies may reveal research findings relating genetic links to mental illness. Adoption studies allow comparisons to be made of the influences of the environment versus genetics.

Cognitive Level: Analysis

Integrated Process: Evaluation

6. Six months after her husband and children were killed in a car accident, a client is diagnosed with ulcerative colitis. The nurse should recognize that this situation validates which study perspective? 1. Neuroendocrinology 2. Psychoimmunology 3. Diagnostic technology 4. Neurophysiology

ANS: 2

Rationale: Psychoimmunology is the branch of medicine that studies the effects of social and psychological factors on the functioning of the immune system. Studies of the biological response to stress hypothesize that individuals become more susceptible to physical illness following exposure to stressful stimuli.

Cognitive Level: Application

Integrated Process: Evaluation

7. A withdrawn client, diagnosed with schizophrenia, expresses little emotion and refuses to attend group therapy. What altered component of the nervous system should a nurse recognize as being responsible for this behavior?

1. Dendrites 2. Axons 3. Neurotransmitters 4. Synapses

ANS: 3

Rationale: The nurse should recognize that neurotransmitters play an essential function in the role of human emotion and behavior. Neurotransmitters are targeted and affected by many psychotropic medications.

Cognitive Level: Comprehension

Integrated Process: Evaluation

8. An instructor is teaching nursing students about neurotransmitters. Which best explains the process of how neurotransmitters released into the synaptic cleft may return to the presynaptic neuron? 1. Regeneration 2. Reuptake 3. Recycling 4. Retransmission

ANS: 2

Rationale: The nursing instructor should explain that the process by which neurotransmitters are released into the synaptic cleft and returned to the presynaptic neuron is termed reuptake.

Reuptake is the process by which neurotransmitters are stored for reuse.

Cognitive Level: Comprehension

Integrated Process: Implementation

9. A nurse concludes that a restless, agitated client is manifesting a fight- or-flight response. The nurse should associate this response with which neurotransmitter?1. Acetylcholine2. Dopamine3. Serotonin4. Norepinephrine

ANS: 4

Rationale: The nurse should associate the neurotransmitter norepinephrine with the fight-or-flight response. Norepinephrine produces activity in the sympathetic postsynaptic nerve terminal and is associated with the regulation of mood, cognition, perception, locomotion, and sleep and arousal.

Cognitive Level: Comprehension

Integrated Process: Assessment

10. A client is admitted to a psychiatric unit with the diagnosis of catatonic schizophrenia. Which of the clients neurotransmitters should a nurse expect to be elevated?1. Serotonin

2. Dopamine

3. Gamma-aminobutyric acid (GABA)

4. Histamine

ANS: 2

Rationale: The nurse should expect that elevated dopamine levels might be an attributing factor to the clients current level of functioning. Dopamine functions include regulation of movements and coordination, emotions, and voluntary decision-making ability.

Cognitive Level: Application

Integrated Process: Assessment

11. A clients wife of 34 years dies unexpectedly. The client cries often and becomes socially isolated. The clients therapist encourages open discussion of feelings, proper nutrition, and exercise. What is the best rationale for the therapists recommendations? 1. The therapist is using an interpersonal approach.2. The client has an alteration in neurotransmitters.

3. It is routine practice to remind clients about nutrition, exercise, and rest.4. The client is susceptible to illness because of effects of stress on the immune system.

ANS: 4

Rationale: The therapists recommendations should be based on the knowledge that the client has been exposed to stressful stimuli and is at an increased risk to develop illness because of the effects of stress on the immune system. The study of this branch of medicine is called psychoimmunology.

Cognitive Level: Application

Integrated Process: Planning

12. Which mental illness should a nurse identify as being associated with a decrease in prolactin hormone level?

1. Major depressive episode2. Schizophrenia

3. Anorexia nervosa4. Alzheimers disease

ANS: 2

Rationale: Although the exact mechanism is unknown, there may be some correlation between decreased levels of the hormone prolactin and schizophrenia.

Cognitive Level: Application

Integrated Process: Evaluation

13. Which cerebral structure should a nursing instructor describe to students as the emotional brain? 1. The cerebellum 2. The limbic system 3. The cortex 4. The left temporal lobe

ANS: 2

Rationale: The limbic system is often referred to as the emotional brain. The limbic system is largely responsible for one's emotional state and is associated with feelings, sexuality, and social behavior.

Cognitive Level: Comprehension

Integrated Process: Implementation

14. A nurse understands that the abnormal secretion of growth hormone may play a role in which illness? 1. Acute mania 2. Schizophrenia 3. Anorexia nervosa 4. Alzheimer's disease

ANS: 3

Rationale: The nurse should understand that research has found a correlation between abnormal levels of growth hormone and anorexia nervosa. The growth hormone is responsible for growth in children, as well as continued protein synthesis throughout life.

Cognitive Level: Comprehension

Integrated Process: Assessment

15. A client is admitted to an emergency department experiencing memory deficits and decreased motor function. What alteration in brain chemistry should a nurse correlate with the production of these symptoms? 1. Abnormal levels of serotonin 2. Decreased levels of dopamine 3. Increased levels of norepinephrine 4. Decreased levels of acetylcholine

ANS: 4

Rationale: The nurse should correlate memory deficits and decreased motor function with decreased levels of acetylcholine. Acetylcholine is a major effector chemical of the autonomic nervous system. Functions of acetylcholine include sleep regulation, pain perception, the modulation and coordination of movement, and memory.

Cognitive Level: Application

Integrated Process: Assessment

16. A nurse should recognize that a decrease in norepinephrine levels would play a significant role in which mental illness? 1. Bipolar disorder: mania 2. Schizophrenia spectrum disorder 3. Generalized anxiety disorder 4. Major depressive episode

ANS: 4

Rationale: The nurse should recognize that a decrease in norepinephrine level would play a significant role in the development of major depressive disorder. The functions of norepinephrine include the regulation of mood, cognition, perception, locomotion, cardiovascular functioning, and sleep and arousal.

Cognitive Level: Application

Integrated Process: Evaluation

17. A nurse should expect that an increase in dopamine activity might play a significant role in the development of which mental illness? 1. Schizophrenia spectrum disorder 2. Major depressive disorder 3. Body dysmorphic disorder 4. Parkinson's disease

ANS: 1

Rationale: The nurse should expect that an increase in dopamine activity might play a significant role in the development of schizophrenia spectrum disorder. Functions of dopamine include regulation of emotions, coordination, and voluntary decision-making ability. Increased dopamine activity is also associated with mania.

Cognitive Level: Application

Integrated Process: Evaluation

Multiple Response

18. Which of the following information should a nurse include when explaining causes of anorexia nervosa to a client? (Select all that apply.) 1. There is a possible correlation between abnormal secretion of growth hormone and anorexia nervosa. 2. There is a possible correlation between antidiuretic hormone levels and anorexia nervosa.

3. There is a possible correlation between low levels of gonadotropin and anorexia nervosa.

4. There is a possible correlation between increased levels of prolactin and anorexia nervosa.

5. There is a possible correlation between altered levels of oxytocin and anorexia nervosa.

ANS: 1, 3

Rationale: The nurse should explain to the client that there is a possible correlation between anorexia nervosa and decreased levels of growth hormones and gonadotropin. Anorexia nervosa has also been correlated with increased cortisol levels.

Cognitive Level: Application

Integrated Process: Implementation

19. Which of the following symptoms should a nurse associate with the development of increased levels of thyroid-stimulating hormone (TSH) in a newly admitted client? (Select all that apply.) 1. Depression 2. Fatigue 3. Increased libido 4. Mania 5. Hyperexcitability

ANS: 1, 2

Rationale: The nurse should associate depression and fatigue with increased levels of TSH. TSH is only increased when thyroid levels are low, as in the diagnosis of hypothyroidism. In addition to depression and fatigue, other symptoms, such as decreased libido, memory impairment, and suicidal ideation are associated with chronic hypothyroidism.

Cognitive Level: Application

Integrated Process: Assessment

Fill-in-the-Blank

20. _____ is the study of the biological foundations of cognitive, emotional, and behavioral processes.

ANS: Psychobiology

Rationale: Psychobiology is the study of the biological foundations of cognitive, emotional, and behavioral processes. In recent years, a greater emphasis has been placed on the study of the organic basis for psychiatric illness.

Chapter 3. Ethical and Legal Issues

Multiple Choice

1. In response to a student's question regarding choosing a psychiatric specialty, a charge nurse states, "Mentally ill clients need special care. If I were in that position, I'd want a caring nurse also. From which ethical framework is the charge nurse operating?"

1. Kantianism
2. Christian ethics
3. Ethical egoism
4. Utilitarianism

ANS: 2

Rationale: The charge nurse is operating from a Christian ethics framework. The imperative demand of Christian ethics is that all decisions about right and wrong should be centered in love for God and in treating others with the same respect and dignity with which we would expect to be treated. Kantianism states that decisions should be made based on moral law and that actions are bound by a sense of moral duty. Utilitarianism holds that decisions should be made focusing on the end result being happiness. Ethical egoism promotes the idea that what is right is good for the individual.

Cognitive Level: Analysis

Integrated Process: Assessment

2. During a hiring interview, which response by a nursing applicant should indicate that the applicant operates from an ethical egoism framework?

1. I would want to be treated in a caring manner if I were mentally ill.
2. This job will pay the bills, and the workload is light enough for me.
3. I will be happy caring for the mentally ill. Working in med/surg kills my back.
4. It is my duty in life to be a psychiatric nurse. It is the right thing to do.

ANS: 2

Rationale: The applicant's comment reflects the ethical egoism framework. This framework promotes the idea that decisions are made based on what is good for the individual and may not take the needs of others into account.

Cognitive Level: Analysis

Integrated Process: Evaluation

3. Without authorization, a nurse administers an extra dose of narcotic tranquilizer to an agitated client. The nurse's coworker observes this action but does nothing for fear of retaliation. What is the ethical interpretation of the coworker's lack of involvement?

1. Taking no action is still considered an unethical action by the coworker.
2. Taking no action releases the coworker from ethical responsibility.
3. Taking no action is advised when potential adverse consequences are foreseen.
4. Taking no action is acceptable, because the coworker is only a bystander.

ANS: 1

Rationale: The coworker's lack of involvement can be interpreted as an unethical action. The