A charge nurse is discussing mental status exams with a newly licensed nurse. Which of the following statements by the newly licensed nurse indicates an understanding of the teaching? (Select all that apply)

A. "To assess cognitive ability, I should ask the client to count backward by sevens."
B. "To assess affect, I should observe the client's facial expression."
C. "To assess language ability, I should instruct the client to write a sentence."
D. "To assess remote memory, I should have the client repeat a list of objects."
E. "To assess the client's abstract thinking, I should ask the client to identify our most recent presidents."

A nurse is planning care for a client who has a mental health disorder. Which of the following actions should the nurse include as a psychobiological intervention?

A. Assist the client with systematic desensitization therapy.
B. Teach the client appropriate coping mechanisms.
C. Assess the client for comorbid health conditions.
D. Monitor the client for adverse effects of the medication.

A nurse in an outpatient mental health clinic is preparing to conduct an initial client interview. When conducting the interview, which of the following actions should the nurse identify as the priority?

A. Coordinate holistic care with social services.
B. Identify the client's perception of her mental health status.
C. Include the client's family in the interview.
D. Teach the client about her current mental health disorder.

A nurse is told during change of shift report that a client is stuporous. When assessing the client, which of the following findings should the nurse expect?

A. The client arouses briefly in response to a sternal rub.
B. The client has a glasgow coma scale score less than 7.
C. The client exhibits decorticate rigidity.
D. The client is alert but disoriented to time and place.
A nurse in an acute mental health facility is assisting with discharge planning for a client who has a severe mental illness and requires supervision much of the time. The client's wife works all day but is home by late afternoon. Which of the following strategies should the nurse suggest as appropriate follow-up care?

A. Receiving daily care from a home health aide  
B. Having a weekly visit from a nurse case worker  
C. Attending a partial hospitalization program  
D. Visiting a community mental health center on a daily basis

A nurse is caring for a group of clients. Which of the following clients should a nurse consider for referral to an assertive community treatment (ACT) group?

A. A client in an acute care mental health facility who has fallen several times while running down the hallway  
B. A client who lives at home and keeps “forgetting” to come in for his monthly antipsychotic injection for schizophrenia  
C. A client in a day treatment program who says he is becoming more anxious during group therapy  
D. A client in a weekly grief support group who says she still misses her deceased husband who has been dead for 3 months

A nurse is teaching a client who has an anxiety disorder and is scheduled to begin classical psychoanalysis. Which of the following client statements indicates an understanding of this form of therapy?

A. "Even if my anxiety improves, I will need to continue this therapy for 6 weeks."  
B. "The therapist will focus on my past relationships during our sessions."  
C. "Psychoanalysis will help me reduce my anxiety by changing my behaviors."  
D. "This therapy will address my conscious feelings about stressful experiences."

A nurse is discussing free association as a therapeutic tool with a client who has major depressive disorder. Which of the following client statements indicates understanding of this technique?

A. "I will write down my dreams as soon as I wake up."  
B. "I may begin to associate my therapist with important people in my life."  
C. "I can learn to express myself in a nonaggressive manner."  
D. "I should say the first thing that comes to my mind."
A nurse is planning care for a client following surgical implantation of a VNS device. The nurse should plan to monitor for which of the following adverse effects? (Select all that apply)

A. Voice changes  
B. Seizure activity  
C. Disorientation  
D. Dysphagia  
E. Neck pain

A nurse observes a client who has OCD repeatedly applying, removing, and then reapplying makeup. The nurse identifies that repetitive behavior in a client who has OCD is due to which of the following underlying reasons?

A. Narcissistic behavior  
B. Fear of rejection from staff  
C. Attempt to reduce anxiety  
D. Adverse effect of antidepressant medication

A nurse is caring for a client who is experiencing a panic attack. Which of the following actions should the nurse take?

A. Discuss new relaxation techniques  
B. Show the client how to change his behavior  
C. Distract the client with a television show  
D. Stay with the client and remain quiet

A nurse is assessing a client who has generalized anxiety disorder. Which of the following findings should the nurse expect? (Select all that apply)

A. Excessive worry for 6 months  
B. Impulsive decision making  
C. Delayed reflexes  
D. Restlessness  
E. Need for reassurance

A nurse is caring for a client who has body dysmorphic disorder. Which of the following actions should the nurse plan to take first?

A. Assessing the client's risk for self harm  
B. Instilling hope for positive outcomes
C. Encouraging the client to participate in group therapy sessions
D. Encouraging the client to participate in treatment decisions

A nurse is caring for a client who has acute stress disorder and is experiencing severe anxiety. Which of the following statements should the nurse make?

A. "Tell me about how you are feeling right now."
B. "You should focus on the positive things in your life to decrease your anxiety."
C. "Why do you believe you are experiencing this anxiety?"
D. "Let's discuss the medications your provider is prescribing to decrease your anxiety."

A nurse working on an acute mental health unit is caring for a client who has PTSD. Which of the following findings should the nurse expect? (Select all that apply)

A. Difficulty concentrating on tasks
B. Obsessive need to talk about the traumatic event
C. Negative self-image
D. Recurring nightmares
E. Diminished reflexes

A nurse is involved in a serious and prolonged mass casualty incident in the emergency department. Which of the following strategies should the nurse use to help prevent developing a trauma-related disorder? (Select all that apply)

A. Avoid thinking about the incident when it is over
B. Take breaks during the incident for food and water
C. Debrief with others following the incident
D. Hold emotions in check in the days following the incident
E. Take advantage of offered counseling

A nurse is collecting an admission history for a client who has acute stress disorder (ASD). Which of the following information should the nurse expect to collect?

A. The client remembers many details about the traumatic incident
B. The client expresses heightened elation about what is happening
C. The client states he first noticed manifestations of the disorder 6 weeks after the traumatic incident occurred.
D. The client expresses a sense of unreality about the traumatic event

A nurse is caring for a client who has derealization disorder. Which of the following findings should the nurse identify as an indication of derealization?

A. The client explains that her body seems to be floating above the ground
B. The client has the idea that someone is trying to kill her and steal her money
A nurse is caring for an adolescent client who has anorexia nervosa with rapid weight loss and a current weight of 90 lb. Which of the following statements indicates the client is experiencing the cognitive distortion catastrophizing?

A. "Life isn't worth living if I gain weight."
B. "Don't pretend like you don't know how fat I am."
C. "If I could be skinny, I know I'd be popular."
D. "When I look in the mirror, I see myself as obese."

A nurse is performing an admission assessment of a client who has bulimia nervosa with purging behavior. Which of the following is an expected finding? (Select all that apply)

A. Amenorrhea
B. Hypokalemia
C. Mottling of the skin
D. Slightly elevated body weight
E. Presence of lanugo on the face

A nurse on an acute care unit is planning care for a client who has anorexia nervosa with binge-eating and purging behavior. Which of the following nursing actions should the nurse include in the client's plan of care?

A. Allow the client to select preferred meal times.
B. Establish consequences for purging behavior.
C. Provide the client with a high-fat diet at the start of treatment.
D. Implement one-to-one observation during meal times.

A nurse is caring for a client who has bulimia nervosa and has stopped purging behavior. The client tells the nurse that she is afraid she is going to gain weight. Which of the following responses should the nurse make?

A. "Many clients are concerned about their weight. However the dietitian will ensure that you don't get too many calories in your diet."
B. "Instead of worrying about your weight, try to focus on other problems at this time."
C. "I understand you have concerns about your weight, but first, let's talk about your recent accomplishments."
D. "You are not overweight, and the staff will ensure that you do not gain weight while you are in the hospital. We know that is important to you."

A nurse is discussing the risk factors for somatic symptom disorder with a newly licensed nurse. Which of the following risk factors should the nurse include? (Select all that apply)