

PRACTICE QUESTIONS ANSWERS AND RATIONALES

The correct answer number and rationale for why it is the correct answer are given in **boldface blue type**. Rationales for why the other answer options are incorrect are also given, but they are not in boldface type.

Theory

1. Inability of the ego to intervene when conflict occurs relates to the psychoanalytic, not cognitive, theory of panic disorder development.
2. Abnormal elevations of blood lactate and increased lactate sensitivity relate to the biological, not cognitive, theory of panic disorder development.
3. Increased involvement of the neurochemical norepinephrine relates to the biological, not cognitive, theory of panic disorder development.
4. **Distorted thinking patterns that precede maladaptive behaviors relate to the cognitive theory perspective of panic disorder development.**

TEST-TAKING HINT: The test taker should note important words in the question, such as “cognitive.” Although all of the answers are potential causes of panic disorder development, the only answer that is from a cognitive perspective is “4.”

2. An overuse or ineffective use of ego defense mechanisms, which results in a maladaptive response to anxiety, is an example of the **psychodynamic** theory of generalized anxiety disorder development.

TEST-TAKING HINT: To answer this question correctly, the test taker should review the various theories related to the development of generalized anxiety disorder.

3. **1. When the client verbalizes understanding of how the experienced event, individual traits, and available support systems affect his or her diagnosis, the client demonstrates a good understanding of the psychosocial cause of posttraumatic stress disorder (PTSD).**
2. Avoiding situations as a way to decrease emotional pain is an example of a learned, not psychosocial, cause of PTSD.
3. The release of natural opioids during a traumatic event is an example of a biological, not psychosocial, cause of PTSD.
4. Having a negative perception of the world because of a traumatic event is an example of a cognitive, not psychosocial, cause of PTSD.

TEST-TAKING HINT: To answer this question correctly, the test taker should review the different theories as they relate to the causes of different

anxiety disorders, including PTSD. Only “1” describes a psychosocial etiology of PTSD.

4. Sending counselors to a natural disaster site to assist individuals to deal with the devastation is an example of **primary** prevention. Primary prevention reduces the incidence of mental disorders, such as posttraumatic stress disorder, within the population by helping individuals to cope more effectively with stress early in the grieving process. Primary prevention is extremely important for individuals who experience any traumatic event, such as a rape, war, hurricane, tornado, or school shooting.

TEST-TAKING HINT: To answer this question correctly, it is necessary to understand the differences between primary, secondary, and tertiary prevention.

5. 1. The belief that individuals diagnosed with obsessive-compulsive disorder (OCD) have weak and underdeveloped egos is an explanation of OCD etiology from a psychoanalytic, not biological, theory perspective.
2. The belief that obsessive and compulsive behaviors are a conditioned response to a traumatic event is an explanation of OCD etiology from a learning theory, not biological theory, perspective.
3. The belief that regression to the pre-Oedipal anal sadistic phase produces the clinical symptoms of OCD is an explanation of OCD etiology from a psychoanalytic, not biological, theory perspective.
4. **The belief that abnormalities in various regions of the brain cause OCD is an explanation of OCD etiology from a biological theory perspective.**

TEST-TAKING HINT: To answer this question correctly, the test taker must understand the different theories of OCD etiology. This question calls for a biological theory perspective, making “4” the only correct choice.

6. When examining theories of phobia etiology, this situation would be reflective of **learning** theory. Some learning theorists believe that fears are conditioned responses, and they are learned by imposing rewards for certain behaviors. In the instance of phobias, when the individual avoids the phobic object, he or she escapes fear, which is a powerful reward. This client has learned that avoiding the stimulus of fire eliminates fear.

TEST-TAKING HINT: To answer this question correctly, the test taker needs to review the different theories of the causation of specific phobias.

7. 1. Offering PRN lorazepam (Ativan) before group is an example of a biological, not intrapersonal, intervention.
2. Attending group with the client is an example of an interpersonal, not intrapersonal, intervention.
3. **Encouraging discussion about fears is an intrapersonal intervention.**
4. Role-playing a scenario that may occur is a behavioral, not intrapersonal, intervention.

TEST-TAKING HINT: It is important to understand that interventions are based on theories of causation. In this question, the test taker needs to know that intrapersonal theory relates to feelings or developmental issues. Only “3” deals with client feelings.

8. 1. Encouraging the client to evaluate the power of distorted thinking is based on a cognitive, not psychodynamic, perspective.
2. Asking the client to include his or her family in scheduled therapy sessions is based on an interpersonal, not psychodynamic, perspective.
3. **The nurse discussing the overuse of ego defense mechanisms illustrates a psychodynamic approach to address the client’s behaviors related to panic disorder.**
4. Teaching the client the effects of blood lactate on anxiety is based on the biological, not psychodynamic, perspective.

TEST-TAKING HINT: When answering this question, the test taker must be able to differentiate among various theoretical perspectives and their related interventions.

9. 1. **Ineffective coping R/T punitive superego reflects an intrapersonal theory of the etiology of obsessive-compulsive disorder (OCD). The punitive superego is a concept contained in Freud’s psychosocial theory of personality development.**
2. Ineffective coping R/T active avoidance reflects a behavioral, not intrapersonal, theory of the etiology of OCD.
3. Ineffective coping R/T alteration in serotonin reflects a biological, not intrapersonal, theory of the etiology of OCD.
4. Ineffective coping R/T classic conditioning reflects a behavioral, not intrapersonal, theory of the etiology of OCD.

TEST-TAKING HINT: To answer this question correctly, the test taker needs to understand the different theories of the etiology of OCD. The

keyword “intrapersonal” should make the test taker look for a concept inherent in this theory, such as “punitive superego.”

10. 1. Encouraging a client to attend group is an interpersonal, not intrapersonal, approach to treating survivor’s guilt associated with PTSD.
2. **Encouraging expressions of feelings during one-to-one interactions with the nurse is an intrapersonal approach to interventions that treat survivor’s guilt associated with PTSD.**
3. Asking the client to challenge the irrational beliefs associated with the event is a cognitive, not intrapersonal, intervention to treat survivor’s guilt associated with PTSD.
4. Administering regularly scheduled paroxetine (Paxil) is a biological, not intrapersonal, intervention to treat survivor’s guilt associated with PTSD.

TEST-TAKING HINT: To answer this question correctly, the test taker needs to differentiate various theoretical approaches and which interventions reflect these theories.

Defense Mechanisms

11. 1. Denial is defined as refusing to acknowledge the existence of a situation or the feelings associated with it. No information is presented in the question that indicates the use of denial.
2. Social isolation is defined as aloneness experienced by the individual and perceived as imposed by others and as a negative or threatening statement. No information is presented in the question that indicates the client is experiencing social isolation.
3. Anger is broadly applicable to feelings of resentful or revengeful displeasure. No information is presented in the question that indicates the client is experiencing anger.
4. **The client in the question is experiencing survivor’s guilt. Survivor’s guilt is a common situation that occurs when an individual experiences a traumatic event in which others died and the individual survived.**

TEST-TAKING HINT: To answer this question correctly, the test taker needs to understand common phenomena experienced by individuals diagnosed with posttraumatic stress disorder and relate this understanding to the client statement presented in the question.

12. 1. Suppression, the voluntary blocking from one’s awareness of unpleasant feelings and experiences, is not a defense mechanism commonly used by individuals diagnosed with OCD.

2. Repression, the involuntary blocking of unpleasant feelings and experiences from one's awareness, is not a defense mechanism commonly used by individuals diagnosed with OCD.
 3. **Undoing is a defense mechanism commonly used by individuals diagnosed with OCD. Undoing is used symbolically to negate or cancel out an intolerable previous action or experience. An individual diagnosed with OCD experiencing intolerable anxiety would use the defense mechanism of undoing to undo this anxiety by substituting obsessions or compulsions or both. Other commonly used defense mechanisms are isolation, displacement, and reaction formation.**
 4. Denial, the refusal to acknowledge the existence of a real situation or the feelings associated with it or both, is not a defense mechanism commonly used by individuals diagnosed with OCD.
2. Teaching the importance of a bedtime routine may be important for clients experiencing a sleep disturbance, but this is an intervention, not an assessment.
 3. Keeping the client's door locked during the day to avoid napping may be important for clients experiencing a sleep disturbance, but this is an intervention, not an assessment.
 4. **An important nursing assessment for a client experiencing a sleep disturbance is to note the client's baseline sleep patterns. These data allow the nurse to recognize alterations in normal patterns of sleep and to intervene appropriately.**

TEST-TAKING HINT: To answer this question correctly, the test taker needs to understand the underlying reasons for the ritualistic behaviors used by individuals diagnosed with OCD.

Nursing Process—Assessment

13. 1. **When the client reports satisfaction with the quality of sleep, the client is providing subjective assessment data. Good sleepers self-define themselves as getting enough sleep and feeling rested. These individuals feel refreshed in the morning, have energy for daily activities, fall asleep quickly, and rarely awaken during the night.**
 2. The number of hours a client has slept during the night is an objective assessment of sleep. Sleep can be observed objectively by noting closed eyes, snoring sounds, and regular breathing patterns.
 3. The use of a sleep scale objectifies the subjective symptom of sleep quality.
 4. The number of midnight awakenings is an objective assessment of sleep. Even though the client reports this assessment, the number of midnight awakenings is objective data.
- TEST-TAKING HINT:** The test taker must look for an answer choice that meets the criteria of a subjective assessment. Subjective symptoms are symptoms of internal origin, evident only to the client.
14. 1. Limiting caffeine intake may be important for clients experiencing a sleep disturbance, but this is an intervention, not an assessment.
 2. Sleep disturbances include hypersomnia and insomnia.
 1. **Chronic conditions, such as arthritis and joint and muscle discomfort and pain, represent some of the many reasons why elderly clients are at an increased risk for sleep disturbances.**
 2. Confusion and wandering as a result of dementia can be a reason why elderly clients are at an increased risk for sleep disturbances.
 3. Inactivity and other psychosocial concerns, such as loneliness or boredom, can be a reason why elderly clients are at an increased risk for sleep disturbances.
 4. Increased anxiety is a reason why elderly clients can be at an increased risk for sleep disturbances.
 5. Medications have many side effects, including insomnia, and medications are metabolized differently in elderly clients. Many elderly clients, because of chronic conditions, experience polypharmacy, and so they are at higher risk for sleep disturbances.
- TEST-TAKING HINT:** To answer this question correctly, the test taker must understand the different biological and psychosocial factors that may influence the sleep patterns of elderly clients.
16. Primary insomnia may manifest by a combination of difficulty falling asleep and intermittent wakefulness during sleep.
 1. **Lack of sleep results in daytime irritability.**
 2. **Lack of sleep results in problems with attention and concentration.**
 3. **Individuals diagnosed with insomnia may inappropriately use substances, including**

hypnotics for sleep and stimulants to counteract fatigue.

4. Nightmares are frightening dreams that occur during sleep. Because clients diagnosed with insomnia have trouble sleeping, nightmares are not a characteristic of this disorder.
5. Sleepwalking is characterized by the performance of motor activity during sleep, not wakefulness, in which the individual may leave the bed and walk about, dress, go to the bathroom, talk, scream, and even drive.

TEST-TAKING HINT: The test taker must recognize the symptoms of insomnia to answer this question correctly.

17. 1. Parasomnia refers to the unusual or undesirable behaviors that occur during sleep (e.g., nightmares, sleep terrors, and sleep walking). Parasomnias are not classified as breathing-related sleep disorders.
2. Hypersomnia refers to excessive sleepiness or seeking excessive amounts of sleep. Hypersomnia is not classified as a breathing-related sleep disorder.
3. **Apnea refers to the cessation of breathing during sleep. To be so classified, the apnea must last for at least 10 seconds and occur 30 or more times during a 7-hour period of sleep. Apnea is classified as a breathing-related sleep disorder.**
4. Cataplexy refers to a sudden, brief loss of muscle control brought on by strong emotion or emotional response, such as a hearty laugh, excitement, surprise, or anger. Cataplexy is not classified as a breathing-related sleep disorder.

TEST-TAKING HINT: To answer this question correctly, the test taker first needs to be familiar with the terminology related to sleep disorders and then to note what affects breathing patterns.

18. The parasomnia of sleep terrors is closely associated with sleepwalking, and often a night terror episode progresses into a sleepwalking episode. Approximately 1% to 6% of children experience sleep terrors, and the incidence seems to be more common in boys than in girls. Resolution usually occurs spontaneously during adolescence. If the disorder begins in adulthood, it usually runs a chronic course.
 1. The client, on awakening, is unable to explain the nightmare. On awakening in the morning, the client experiences amnesia about the entire episode.
 2. The client is not easily awakened after the night terror. The client is often difficult to awaken or comfort.

3. **During a sleep terror, the client does experience an abrupt arousal from sleep with a piercing scream or cry.**

4. The client, on awakening during a night terror, is usually disoriented, not alert and oriented. The client expresses a sense of intense fear, but cannot recall the dream episode.

TEST-TAKING HINT: To answer this question correctly, the test taker must understand the characteristics associated with sleep terrors.

19. 1. **A client diagnosed with posttraumatic stress disorder (PTSD) may have dissociative events in which the client feels detached from the situation or feelings.**
2. **A client diagnosed with PTSD may have intense fear and feelings of helplessness.**
3. A client diagnosed with PTSD has feelings of detachment or estrangement toward others, not excessive attachment and dependence.
4. A client diagnosed with PTSD has restricted, not full, range of affect.
5. **A client diagnosed with PTSD avoids activities associated with the traumatic event.**

TEST-TAKING HINT: To answer this question correctly, the test taker must be aware of the different symptoms associated with the diagnosis of PTSD.

20. 1. The degree of ego strength is a part of individual variables, not part of the recovery environment. Other variables of the individual include effectiveness of coping resources, presence of preexisting psychopathology, outcomes of previous experiences with stress and trauma, behavioral tendencies (e.g., temperament), current psychosocial developmental stage, and demographic factors (socioeconomic status and education).
2. **Availability of social supports is part of environmental variables. Others include cohesiveness and protectiveness of family and friends, attitudes of society regarding the experience, and cultural and subcultural influences.**
3. Severity and duration of the stressor is a variable of the traumatic experience, not part of the recovery environment. Other variables of the traumatic experience include amount of control over the recurrence, extent of anticipatory preparation, exposure to death, the number affected by the life-threatening situation, and location where the traumatic event was experienced.
4. Amount of control over the recurrence is a variable of the traumatic experience, not part of the recovery environment.

TEST-TAKING HINT: To answer this question correctly, the test taker needs to understand the following three significant elements in the development of posttraumatic stress disorder: traumatic experience, individual variables, and environmental variables.

21. 1. Recurrent distressing flashbacks are emotional, not behavioral, symptoms of posttraumatic stress disorder (PTSD).
 2. Intense fear, helplessness, and horror are cognitive, not behavioral, symptoms of PTSD.
 3. **Diminished participation in significant activities is a behavioral symptom of PTSD.**
 4. Detachment or estrangement from others are interpersonal, not behavioral, symptoms of PTSD.

TEST-TAKING HINT: To answer this question correctly, the test taker should take note of the keyword “behavioral,” which determines the correct answer. All symptoms may be exhibited in PTSD, but only answer choice “3” is a behavioral symptom.

22. 1. A client fearful of spiders is experiencing arachnophobia, not acrophobia.
 2. **Acrophobia is the fear of heights. An individual experiencing acrophobia may be unable to fly because of this fear.**
 3. A client fearful of marriage is experiencing gamophobia, not acrophobia.
 4. A client fearful of lightning is experiencing astraphobia, not acrophobia.

TEST-TAKING HINT: To answer this question correctly, the test taker needs to review the definitions of specific commonly diagnosed phobias.

23. 1. A client cannot be diagnosed with social phobia when under the influence of substances such as marijuana. It would be unclear if the client is experiencing the fear because of the mood-altering substance or a true social phobia.
 2. Children can be diagnosed with social phobias. However, in children, there must be evidence of the capacity for age-appropriate social relationships with familiar people, and the anxiety must occur in peer and adult interactions.
 3. If a general medical condition or another mental disorder is present, the social phobia must be unrelated. If the fear is related to the medical condition, the client cannot be diagnosed with a social phobia.
 4. **A student who avoids classes because of the fear of being scrutinized by others meets the criteria for a diagnosis of social phobia.**

TEST-TAKING HINT: The test taker must understand the DSM-IV-TR diagnostic criteria for social phobia to answer this question correctly.

24. 1. Fear of dying is an affective, not physical, symptom of a panic attack.
 2. **Sweating and palpitations are physical symptoms of a panic attack.**
 3. Depersonalization is an alteration in the perception or experience of the self, so that the feeling of one’s own reality is temporarily lost. Depersonalization is a cognitive, not physical, symptom of a panic attack.
 4. Restlessness and pacing are behavioral, not physical, symptoms of a panic attack.

TEST-TAKING HINT: The test taker must note important words in the question, such as “physical symptoms.” Although all the answers are actual symptoms a client experiences during a panic attack, only “2” is a physical symptom.

25. 1. **Using excessive hand washing to relieve anxiety is a behavioral symptom exhibited by clients diagnosed with obsessive-compulsive disorder (OCD).**
 2. The verbalization of anxiety is not classified as a behavioral symptom of OCD.
 3. Using breathing techniques to decrease anxiety is a behavioral intervention, not a behavioral symptom.
 4. Excessive sweating and increased pulse are biological, not behavioral, symptoms of OCD.

TEST-TAKING HINT: To answer this question correctly, the test taker must be able to differentiate various classes of symptoms exhibited by clients diagnosed with OCD. The keyword “behavioral” determines the correct answer to this question.

26. 1. Although the client may be exhibiting signs and symptoms of an exacerbation of generalized anxiety disorder, the nurse cannot assume this to be true before a thorough assessment is done.
 2. Although the client may be experiencing an underlying medical condition that is causing the anxiety, the nurse cannot assume this to be true before a thorough assessment is done.
 3. **Physical problems should be ruled out before determining a psychological cause for this client’s symptoms.**
 4. Although the client may need an anxiolytic dosage increase, the nurse cannot assume this to be true before a thorough physical assessment is done.

TEST-TAKING HINT: The test taker needs to remember that although a client may have a history of a psychiatric illness, a complete, thorough evaluation must be done before assuming

exhibited symptoms are related to the psychiatric diagnosis. Many medical conditions generate anxiety as a symptom.

27. 1. **Chronic obstructive pulmonary disease causes shortness of breath. Air deprivation causes anxiety, sometimes to the point of panic.**
2. **Hyperthyroidism (Graves's disease) involves excess stimulation of the sympathetic nervous system and excessive levels of thyroxine. Anxiety is one of several symptoms brought on by these increases.**
3. Hypertension is an often asymptomatic disorder characterized by persistently elevated blood pressure. Hypertension may be caused by anxiety, in contrast to anxiety being the result of hypertension.
4. Diverticulosis results from the outpocketing of the colon. Unless these pockets become inflamed, diverticulosis is generally asymptomatic.
5. **Marked irritability and anxiety are some of the many symptoms associated with hypoglycemia.**

TEST-TAKING HINT: To answer this question correctly, the test taker needs to understand that anxiety is manifested by physiological responses.

28. 1. A client cannot be diagnosed with an anxiety disorder if anxiety is experienced in only one area of functioning.
2. Although anxiety does need to be experienced for a period of time before being diagnosed as an anxiety disorder, this answer states "one" area of functioning and so is incorrect.
3. **For a client to be diagnosed with an anxiety disorder, the client must experience symptoms that interfere in a minimum of two areas, such as social, occupational, or other important functioning. These symptoms must be experienced for durations of 6 months or longer.**
4. A client needs to experience high levels of anxiety that affect functioning in a minimum of two areas of life, and these must have durations of 6 months or longer.

TEST-TAKING HINT: To answer this question correctly, the test taker must understand that specific symptoms must be exhibited and specific timeframes achieved for clients to be diagnosed with anxiety disorders.

29. 1. **A client diagnosed with generalized anxiety disorder (GAD) would experience excessive worry about items difficult to control.**
2. **A client diagnosed with GAD would experience muscle tension.**

3. A client diagnosed with GAD would experience insomnia, not hypersomnia. Sleep disturbances would include difficulty falling asleep, difficulty staying asleep, and restless sleep.
4. A client diagnosed with GAD would be easily fatigued and not experience excessive amounts of energy.
5. **A client diagnosed with GAD would experience an increased startle reflex and tension, causing feelings of being "keyed up" or being "on edge."**

TEST-TAKING HINT: To answer this question correctly, the test taker would need to recognize the signs and symptoms of GAD.

30. 1. Compulsive behaviors that occupy many hours per day would be a behavioral, not cognitive, symptom experienced by clients diagnosed with obsessive-compulsive disorder (OCD).
2. **Excessive worrying about germs and illness is a cognitive symptom experienced by clients diagnosed with OCD.**
3. Comorbid abuse of alcohol to decrease anxiety would be a behavioral, not cognitive, symptom experienced by clients diagnosed with OCD.
4. Excessive sweating and increased blood pressure and pulse are physiological, not cognitive, symptoms experienced by clients diagnosed with OCD.

TEST-TAKING HINT: To answer this question correctly, the test taker must note the keyword "cognitive." Only "2" is a cognitive symptom.

Nursing Process—Diagnosis

31. Hypersomnia, or somnolence, can be defined as excessive sleepiness or seeking excessive amounts of sleep. Excessive sleepiness interferes with attention, concentration, memory, and productivity. It also can lead to disruption in social and family relationships. Depression is a common side effect of hypersomnia, as are substance-related disorders.

1. **Verbalizations of worthlessness may indicate that this client is experiencing suicidal ideations. After assessing suicide risk further, the risk for suicide should be prioritized.**
2. Social isolation R/T sleepiness would be an appropriate nursing diagnosis for a client diagnosed with hypersomnia because of limited contact with others as a result of increased sleep. Compared with the other nursing diagnoses presented, however, this diagnosis would not take priority.

3. Self-care deficit R/T increased need for sleep AEB being unable to bathe without assistance would be an appropriate nursing diagnosis for a client diagnosed with hypersomnia because of the limited energy for bathing related to increased sleepiness. Compared with the other nursing diagnoses presented, however, this diagnosis would not take priority.
4. Chronic low self-esteem R/T inability to function AEB the statement, “I feel worthless,” is an appropriate nursing diagnosis for a client diagnosed with hypersomnia. Compared with the other nursing diagnoses presented, however, this diagnosis would not take priority.

TEST-TAKING HINT: All the nursing diagnoses presented document problems associated with hypersomnia. Because the nurse always prioritizes safety, the nursing diagnosis of risk for suicide takes precedence.

- 32.** 1. Although posttrauma syndrome is an appropriate nursing diagnosis for this client, it is not the priority nursing diagnosis at this time.
2. Although social isolation is an appropriate nursing diagnosis for this client, it is not the priority nursing diagnosis at this time.
3. Although ineffective coping may be an appropriate nursing diagnosis for clients diagnosed with posttraumatic stress disorder, there is no information in the question to suggest alcohol use.
4. **Risk for injury is the priority nursing diagnosis for this client. In the question, the client is exhibiting recurrent flashbacks, nightmares, and sleep deprivation that can cause exhaustion and lead to injury. It is important for the nurse to prioritize the nursing diagnosis that addresses safety.**

TEST-TAKING HINT: When the question asks for a priority, it is important for the test taker to understand that all answer choices may be appropriate statements. Client safety always should be prioritized.

- 33.** 1. **According to the North American Nursing Diagnosis Association (NANDA), the nursing diagnosis format must contain three essential components: (1) identification of the health problem, (2) presentation of the etiology (or cause) of the problem, and (3) description of a cluster of signs and symptoms known as “defining characteristics.” The correct answer, “1,” contains all three components in the correct order: health**

problem/NANDA stem (social isolation); etiology/cause, or R/T (fear of germs); and signs and symptoms, or AEB (refusing to leave home for the past year). Because this client has been unable to leave home for a year as a result of fear of germs, the client’s behaviors meet the defining characteristics of social isolation.

2. Obsessive-compulsive disorder is a medical diagnosis and cannot be used in any component of the nursing diagnosis format. Nursing diagnoses are functional client problems that fall within the scope of nursing practice. Also missing from this nursing diagnosis are the signs and symptoms, or AEB, component of the problem.
3. The etiology (R/T) and signs and symptoms (AEB) are out of order in this nursing diagnostic statement.
4. The inability to leave home is a sign or symptom, which is the third component of the nursing diagnosis format (AEB) not the cause of the problem (R/T statement).

TEST-TAKING HINT: To answer this question correctly, the test taker needs to know the components of a correctly stated nursing diagnosis and the order in which these components are written.

- 34.** 1. Although ineffective breathing patterns would be an appropriate nursing diagnosis during a panic attack, the client in the question is not experiencing a panic attack, and so this nursing diagnosis is inappropriate at this time.
2. Although impaired spontaneous ventilation would be an appropriate nursing diagnosis during a panic attack, the client in the question is not experiencing a panic attack, and so this nursing diagnosis is inappropriate at this time.
3. **Social isolation is seen frequently with individuals diagnosed with panic attacks. The client in the question expresses anticipatory fear of unexpected attacks, which affects the client’s ability to interact with others.**
4. Nothing in the question indicates that the client has a knowledge deficit related to triggers for panic attacks. The client in the question is expressing fear as it relates to the unpredictability of panic attacks.

TEST-TAKING HINT: To answer this question correctly, the test taker must link the behaviors presented in the question with the nursing diagnosis that is reflective of these behaviors. The test taker must remember the importance of time-wise interventions. Nursing interventions differ according to the degree of anxiety the

client is experiencing. If the client were currently experiencing a panic attack, other interventions would be appropriate.

- 35. 1. Anxiety is the underlying cause of the diagnosis of obsessive compulsive disorder (OCD), therefore, anxiety R/T obsessive thoughts is the priority nursing diagnosis for the client newly admitted for the treatment of this disorder.**
2. Powerlessness R/T ritualistic behaviors is an appropriate nursing diagnosis for a client diagnosed with OCD; however, for the client to begin working on feelings of powerlessness, the level of anxiety must be decreased first.
 3. Fear R/T a traumatic event AEB stimulus avoidance would be an appropriate nursing diagnosis for a client diagnosed with post-traumatic stress disorder, not for a client diagnosed with OCD.
 4. Social isolation R/T increased levels of anxiety is an appropriate diagnosis for a client diagnosed with OCD; however, anxiety must be decreased before the client can work on socializing.

TEST-TAKING HINT: When the question is asking for a priority, the test taker should consider which client problem would need to be addressed before any other problem can be explored. When anxiety is decreased, social isolation should improve, and feelings about powerlessness can be expressed.

- 36. 1.** Because safety is always a priority, and this client is expressing suicidal ideations, hopelessness, although appropriate for a client diagnosed with generalized anxiety disorder (GAD), would not be the priority nursing diagnosis at this time.
2. Because safety is always a priority, and this client is expressing suicidal ideations, ineffective coping, although appropriate for a client diagnosed with GAD, would not be the priority nursing diagnosis at this time.
 3. Because safety is always a priority, and this client is expressing suicidal ideations, anxiety, although appropriate for a client diagnosed with GAD, would not be the priority nursing diagnosis at this time.
 4. **Because the client is expressing suicidal ideations, the nursing diagnosis of risk for suicide takes priority at this time. Client safety is prioritized over all other client problems.**

TEST-TAKING HINT: When looking for a priority nursing diagnosis, the test taker always must prioritize client safety. Even if other problems exist, client safety must be ensured.

Nursing Process—Planning

- 37. 1.** Although the nurse may want the client to use one coping skill before bedtime to assist in falling asleep, there is no timeframe on this outcome, and it is not measurable.
2. The outcome of being able to sleep 6 to 8 hours a night and report a feeling of being rested has no timeframe and is not measurable.
 3. **The client's being able to ask for prescribed PRN medication to assist with falling asleep by day 2 is a short-term outcome that is specific, has a timeframe, and relates to the stated nursing diagnosis.**
 4. Although the nurse may want the client to verbalize a decreased level of anxiety, this outcome does not have a timeframe and is not measurable.

TEST-TAKING HINT: When given a nursing diagnosis in the question, the test taker should choose the outcome that directly relates to the client's specific problem. If a client had a nursing diagnosis of disturbed sleep patterns R/T frequent naps during the day, the short-term outcome for this client may be "the client will stay in the milieu for all scheduled groups by day 2." Staying in the milieu would assist the client in avoiding napping, which is the cause of this client's problem.

- 38. 1. It is a realistic expectation for a client who copes with previous trauma by abusing alcohol to recognize the triggers that precipitate this behavior. This outcome should be developed mutually early in treatment.**
2. Attending follow-up weekly therapy sessions after discharge is a long-term, not short-term, outcome.
 3. Expecting the client to refrain from self-blame regarding the rape by day 2 would be an unrealistic outcome. Clients who experience traumatic events need extensive outpatient therapy.
 4. Being free from injury does not relate to the nursing diagnosis of ineffective coping.

TEST-TAKING HINT: It is important to relate outcomes to the stated nursing diagnosis. In this question, the test taker should choose an answer that relates to the nursing diagnosis of ineffective coping. Answer "4" can be eliminated immediately because it does not assist the client in coping more effectively. Also, the test taker must note important words, such as "short-term." Answer "2" can be eliminated immediately because it is a long-term outcome.

39. 1. A client diagnosed with posttraumatic stress disorder experiencing acute flashbacks would need special treatment. An inexperienced agency nurse may find this situation overwhelming.
2. A client diagnosed with generalized anxiety disorder beginning benzodiazepine therapy for the first time may have specific questions about the disease process or prescribed medication. An inexperienced agency nurse may be unfamiliar with client teaching needs.
3. **A client admitted 4 days ago with a diagnosis of agoraphobia, fear of pain, would be an appropriate assignment for the agency nurse. Of the clients presented, this client would pose the least challenge to a nurse unfamiliar with psychiatric clients.**
4. A client with obsessive-compulsive disorder would need to be allowed to use his or her ritualistic behaviors to control anxiety to a manageable level. An inexperienced agency nurse may not fully understand client behaviors that reflect the diagnosis of obsessive-compulsive disorder and may intervene inappropriately.

TEST-TAKING HINT: To answer this question correctly, the test taker needs to recognize the complexity of psychiatric diagnoses and understand the ramifications of potentially inappropriate nursing interventions by inexperienced staff members.

40. 1. **Expecting the client to participate in a set number of group activities by day 4 directly relates to the stated nursing diagnosis of social isolation and is a measurable outcome that includes a timeframe.**
2. Although the nurse may want the client to use relaxation techniques to decrease anxiety, this outcome does not have a timeframe and is not measurable.
3. Having the client verbalize one positive attribute about self by discharge relates to the nursing diagnosis of low self-esteem, not social isolation.
4. Buspirone (BuSpar) is not used on a PRN basis, and so this is an inappropriate outcome for this client.

TEST-TAKING HINT: To express an appropriate outcome, the statement must be related to the stated problem, be measurable and attainable, and have a timeframe. The test taker can eliminate “2” immediately because there is no timeframe, and then “3” because it does not relate to the stated problem.

41. 1. **Remaining safe throughout the duration of the panic attack is the priority outcome for the client.**

2. Although a decreased anxiety level is a desired outcome for a client experiencing panic, this outcome is not measurable because it contains no timeframe.
3. Although the use of coping mechanisms to decrease anxiety is a desired outcome, this outcome is not measurable because it contains no timeframe.
4. The verbalization of the positive effects of exercise is a desired outcome, and it contains a timeframe that is measurable. This would be an unrealistic outcome, however, for a client experiencing a panic attack.

TEST-TAKING HINT: All outcomes must be appropriate for the situation described in the question. In the question, the client is experiencing a panic attack; having the client verbalize the positive effects of exercise would be inappropriate. All outcomes must be client-centered, specific, realistic, positive, and measurable, and contain a timeframe.

42. 1. A client newly admitted with a panic attack history does not command the immediate attention of the nurse. If the client presents with signs and symptoms of panic, the nurse’s priority would then shift to this client.
2. The nurse would assess a client experiencing flashbacks during the night, but this assessment would not take priority at this time over the other clients described.
3. **A client pacing the halls and experiencing an increase in anxiety commands immediate assessment. If the nurse does not take action on this assessment, there is a potential for client injury to self or others.**
4. A client with generalized anxiety disorder awaiting discharge does not command the immediate attention of the nurse. To meet the criteria for discharge, this client should be in stable mental condition.

TEST-TAKING HINT: When the nurse is prioritizing client assessments, it is important to note which client might be a safety risk. When asked to prioritize, the test taker must review all the situations presented before deciding which one to address first.

43. 1. It is unrealistic to expect the client to use a thought-stopping technique totally to eliminate obsessive or compulsive behaviors by day 4 of treatment.
2. It is unrealistic for clients diagnosed with obsessive-compulsive disorder to abruptly stop obsessive or compulsive behaviors.
3. It is desirable for the client to seek assistance from the staff to decrease the amount of obsessive or compulsive behaviors. However,

this outcome should be prioritized earlier than day 4 of treatment.

4. **By day 4, it would be realistic to expect the client to use one relaxation technique to decrease obsessive or compulsive behaviors. This would be the current priority outcome.**

TEST-TAKING HINT: The test taker must recognize the importance of time-wise interventions when establishing outcomes. In the case of clients diagnosed with obsessive-compulsive disorder, expectations on admission vary greatly from outcomes developed closer to discharge.

44. **1. The client's being able to intervene before reaching panic levels of anxiety by discharge is measurable, relates to the stated nursing diagnosis, has a timeframe, and is an appropriate short-term outcome for this client.**
 2. The "verbalization of decreased levels of anxiety" in this outcome is neither specific nor measurable. Instead of a general "decrease" in anxiety, the use of an anxiety scale would make this outcome measurable.
 3. The client's taking control of life situations by effectively using problem-solving methods relates to the stated nursing diagnosis; however, it does not have a timeframe and so is not measurable.
 4. The client's being able to participate voluntarily in group therapy activities is a short-term outcome; however, this outcome does not relate to the stated nursing diagnosis.

TEST-TAKING HINT: When evaluating outcomes, the test taker must make sure that the outcome is specific to the client's need, is realistic, is measurable, and contains a reasonable timeframe. If any of these components is missing, the outcome is incorrectly written and can be eliminated.

Nursing Process—Intervention

45. The parasomnia of nightmare disorder is diagnosed when there is a repeated occurrence of frightening dreams that interfere with social or occupational functioning. Nightmares are common between the ages of 3 and 6 years, and most children outgrow the phenomenon. The individual is usually fully alert on awakening from the nightmare and, because of the lingering fear or anxiety, may have difficulty returning to sleep.

1. **Family stress can occur as the result of repeated client nightmares. This stress within the family may exacerbate the client's problem and hamper any effective treatment. Involving the family in therapy to relieve obvious stress would be an appropriate intervention to assist in the treatment of clients diagnosed with a nightmare disorder.**
2. Phototherapy to assist clients to adapt to changes in sleep would be an appropriate intervention for clients diagnosed with circadian rhythm sleep disorders, not nightmare disorder. Phototherapy, or "bright light" therapy, has been shown to be effective in treating the circadian rhythm sleep disorders of delayed sleep phase disorder and jet lag.
3. **Administering medications such as tricyclic antidepressants or low-dose benzodiazepines or both is an appropriate intervention for clients diagnosed with a parasomnia disorder, such as a nightmare disorder.**
4. Giving central nervous system stimulants, such as amphetamines, would be an appropriate intervention for clients diagnosed with hypersomnia, not a nightmare disorder.
5. **Relaxation therapy, such as meditation and deep breathing techniques, would be appropriate for clients diagnosed with a nightmare disorder to assist in falling back to sleep after the nightmare occurs.**

TEST-TAKING HINT: To answer this question correctly, the test taker must be able first to understand the manifestation of a nightmare disorder and then to choose the interventions that would address these manifestations effectively.

46. Sleepwalking is considered a parasomnia. Sleepwalking is characterized by the performance of motor activity during sleep in which the individual may leave the bed and walk about, dress, go to the bathroom, talk, scream, or even drive.
 1. **Equipping the bed with an alarm that activates when the bed is exited is a priority nursing intervention. During a sleepwalking episode, the client is at increased risk for injury, and interventions must address safety.**
 2. Discouraging strenuous exercise before bedtime is an appropriate intervention to promote sleep; however, this intervention does not take priority over safety.
 3. Limiting caffeine-containing substances within 4 hours of bedtime is an appropriate intervention to promote sleep; however, this intervention does not take priority over safety.

4. Encouraging activities that prepare one for sleep, such as soft music, is an appropriate intervention to promote sleep; however, this intervention does not take priority over safety.

TEST-TAKING HINT: To answer this question correctly, the test taker must understand that a client experiencing sleepwalking is at increased risk for injury. An intervention that addresses safety concerns must be prioritized.

47. 1. **During a flashback, the client is experiencing severe-to-panic levels of anxiety; the priority nursing intervention is to maintain and reassure the client of his or her safety and security. The client's anxiety needs to decrease before other interventions are attempted.**
2. Encouraging the client to express feelings during a flashback would only increase the client's level of anxiety. The client's anxiety level needs to decrease to a mild or moderate level before the nurse encourages the client to express feelings.
3. Although the nurse may want to decrease external stimuli in an attempt to reduce the client's anxiety, ensuring safety and security takes priority.
4. It is important for the nurse to be nonjudgmental and use a matter-of-fact approach when dealing with a client experiencing a flashback. However, because this client is experiencing a severe-to-panic level of anxiety, safety is the priority.

TEST-TAKING HINT: It is important to understand time-wise interventions when dealing with individuals experiencing anxiety. When the client experiences severe-to-panic levels of anxiety during flashbacks, the nurse needs to maintain safety and security until the client's level of anxiety has decreased.

48. 1. If a client is being admitted for panic attacks because of feeling hopeless and helpless, the client is seeking help; elopement precautions are not yet necessary. If behaviors indicate that the client is a danger to self or others, and the client has intentions of leaving the unit, treatment team discussions of elopement precautions are indicated.
2. **Any client who is exhibiting hopelessness or helplessness needs to be monitored closely for suicide intentions.**
3. There is no information in the question that supports the need for homicide precautions.
4. There is no information in the question that supports the need for fall precautions.

TEST-TAKING HINT: To answer this question correctly, the test taker should note the words "hopelessness" and "helplessness," which would be indications of suicidal ideations that warrant suicide precautions.

49. 1. The nurse would include, not notify, the client when making decisions to limit compulsive behaviors. To be successful, the client and the treatment team must be involved with the development of the plan of care.
2. **It is important for the client to learn techniques to reduce overall levels of anxiety to decrease the need for compulsive behaviors. The teaching of these techniques should begin by day 4.**
3. By day 4, the nurse, with the client's input, should begin setting limits on the compulsive behaviors.
4. The client, not the nurse, should say the word "stop" as a technique to limit obsessive thoughts and behaviors.

TEST-TAKING HINT: To answer this question correctly, the test taker must understand that nursing interventions should be based on timeframes appropriate to the expressed symptoms and severity of the client's disorder. The length of hospitalization also must be considered in planning these interventions. The average stay on an in-patient psychiatric unit is 5 to 7 days.

50. 1. **When a client is newly admitted, it is important for the nurse to assess past coping mechanisms and their effects on anxiety. Assessment is the first step in the nursing process, and this information needs to be gathered to intervene effectively.**
2. **Allowing time for the client to complete compulsions is important for a client who is newly admitted. If compulsions are limited, anxiety levels increase. If the client had been hospitalized for a while, then, with the client's input, limits would be set on the compulsive behaviors.**
3. The nurse would set limits on ritualistic behaviors, with the client's input, later in the treatment process, not when a client is newly admitted.
4. A newly admitted client who is exhibiting compulsions is experiencing a high level of anxiety. To present the impact of these compulsions on daily living would be inappropriate at this time and may lead to further increases in anxiety. Clients diagnosed with obsessive-compulsive disorder are aware that their compulsions are "different."

5. It is important for the nurse to allow the client to express his or her feelings about the obsessions and compulsions. This assessment of feelings should begin at admission.

TEST-TAKING HINT: It is important for the test taker to note the words “newly admitted” in the question. The nursing interventions implemented vary and are based on length of stay on the unit, along with client’s insight into his or her disorder. For clients with obsessive-compulsive disorder, it is important to understand that the compulsions are used to decrease anxiety. If the compulsions are limited, anxiety increases. Also, the test taker must remember that during treatment it is imperative that the treatment team includes the client in decisions related to any limitation of compulsive behaviors.

51. 1. The nurse should recognize the statement, “I can’t do this anymore,” as evidence of hopelessness and assess further the potential for suicidal ideations.
2. Removing all potentially harmful objects from the milieu can be an appropriate intervention, but only after the severity of client risk is determined. This assessment is critical for the nurse to intervene appropriately and in a timely manner.
3. Placing the client on a one-to-one observation status can be an appropriate intervention, but only after the severity of client risk is determined. This assessment is critical for the nurse to intervene appropriately and in a timely manner.
4. Although it is important for the client to verbalize feelings, this does not take priority at this time. Suicidal risk needs to be determined to ensure client safety by implementation of appropriate and timely nursing interventions.

TEST-TAKING HINT: To answer this question correctly, the test taker should apply the nursing process. Assessment is the first step of this process. The nurse initially must assess a situation before determining appropriate nursing interventions.

52. 1. Although it is important to teach the client relaxation techniques, this is not the current priority. The client has expressed suicidal ideations, and the priority is to assess the suicide plan further.
2. It is important for the nurse to ask the client about a potential plan for suicide to intervene in a timely manner. Clients who have developed suicide plans are at higher risk than clients who may have vague suicidal thoughts.

3. The nurse may want to call the physician to obtain a PRN order for anxiolytic medications; however, a thorough physical evaluation and further assessment of suicidal ideations need to occur before calling the physician.
4. It is important for the client to participate in group activities. However, the nurse’s first priority is assessing suicidal ideations and developing a plan to intervene quickly and appropriately to maintain client safety.

TEST-TAKING HINT: To answer this question correctly, the test taker must understand the importance of assessing the plan for suicide. Interventions would differ depending on the client’s plan. The intervention for a plan to use a gun at home would differ from an intervention for a plan to hang oneself during hospitalization.

Nursing Process—Evaluation

53. 1. Although the nurse would like the client to express feelings about the experienced nightmares, this statement does not relate to the nursing diagnosis of disturbed sleep patterns.
2. Although the client requests the prescribed trazodone (Desyrel) to assist with falling asleep, there is no assessment information to indicate that this medication has resolved the sleep pattern problem.
3. The client’s feeling rested on awakening and denying nightmares are the evaluation data needed to support the fact that the nursing diagnosis of disturbed sleep patterns R/T nightmares has been resolved.
4. When the client avoids daytime napping, the client has employed a strategy to enhance nighttime sleeping. However, this is not evaluation information that indicates the disturbed sleep problem has been resolved.

TEST-TAKING HINT: To answer this question correctly, the test taker needs to discern evaluation data that indicate problem resolution. Answers “1,” “2,” and “4” all are interventions to assist in resolving the stated nursing diagnosis, not evaluation data that indicate problem resolution.

54. 1. It is impossible for clients to eliminate anxiety from daily life. Mild anxiety is beneficial and necessary to completing tasks of daily living.
2. Optimally, a client should be able to perform activities of daily living independently by discharge; however, this client action does not indicate successful teaching about breathing techniques.

3. It is important that a client recognizes signs and symptoms of escalating anxiety, but this client action does not indicate successful teaching about breathing techniques.
4. **A client's ability to maintain an anxiety level of 3/10 without medications indicates that the client is using breathing techniques successfully to reduce anxiety.**

TEST-TAKING HINT: To answer this question correctly, the test taker should understand that anxiety cannot be eliminated from life. This understanding would eliminate "1" immediately.

55. 1. **This statement is an indication that the cognitive intervention was successful. By remembering that panic attacks are self-limiting, the client is applying the information gained from the nurse's cognitive intervention.**
2. This statement is an indication that a behavioral, not cognitive, intervention was implemented by the nurse. From a behavioral perspective, the nurse has taught this client that exercise can decrease anxiety.
 3. This statement is an indication that the nurse implemented a biological, not cognitive, intervention. From a biological perspective, the nurse has taught this client that anxiolytic medication can decrease anxiety.
 4. This statement is an indication that the nurse implemented an interpersonal, not cognitive, intervention. From an interpersonal perspective, the nurse has taught this client that a social support system can decrease anxiety.

TEST-TAKING HINT: To answer this question correctly, the test taker needs to understand which interventions support which theories of causation. When looking for a "cognitive" intervention, the test taker must remember that the theory involves thought processes.

Psychopharmacology

56. 1. **Clonidine hydrochloride (Catapres) is used in the treatment of panic disorders and generalized anxiety disorder.**
2. **Fluvoxamine maleate (Luvox) is used in the treatment of obsessive-compulsive disorder.**
 3. **Bupirone (BuSpar) is used in the treatment of panic disorders and generalized anxiety disorders.**
 4. **Alprazolam (Xanax), a benzodiazepine, is used for the short-term treatment of anxiety disorders.**

5. Haloperidol (Haldol) is an antipsychotic used to treat thought disorders, not anxiety disorders.

TEST-TAKING HINT: To answer this question correctly, the test taker needs to understand that many medications are used off-label to treat anxiety disorders.

57. The client can receive **4** PRN doses. Medications are given four times in a 24-hour period when the order reads q6h: $1.5 \text{ mg} \times 4 = 6 \text{ mg}$. The test taker must factor in $2 \text{ mg bid} = 4 \text{ mg}$. These two dosages together add up to 10 mg, the maximum daily dose of alprazolam (Xanax), and so the client can receive all 4 PRN doses.

TEST-TAKING HINT: To answer this question correctly, the test taker must recognize that the timing of standing medication may affect the decision-making process related to administration of PRN medications. In this case, the client would be able to receive all possible doses of PRN medication because the standing and PRN ordered medications together do not exceed the maximum daily dose.

58. Bupirone (BuSpar) is an antianxiety medication that does not depress the central nervous system the way benzodiazepines do. Although its action is unknown, the drug is believed to produce the desired effects through interactions with serotonin, dopamine, and other neurotransmitter receptors.
1. Alcohol consumption is contraindicated while taking any psychotropic medication; however, bupirone (BuSpar) does not depress the central nervous system, and so there is no additive effect.
 2. **It is important to teach the client that the onset of action for bupirone (BuSpar) is 2 to 3 weeks. Often the nurse may see a benzodiazepine, such as clonazepam, prescribed because of its quick onset of effect, until the bupirone begins working.**
 3. Bupirone (BuSpar) is not effective in PRN dosing because of the length of time it takes to begin working. Benzodiazepines have a quick onset of effect and are used PRN.
 4. No current lab tests monitor bupirone (BuSpar) toxicity.

TEST-TAKING HINT: To answer this question correctly, the test taker must understand that bupirone (BuSpar) has a delayed onset of action, which can affect medication compliance. If the effects of the medication are delayed, the client is likely to stop taking the medication. Teaching about delayed onset is an important nursing intervention.

59. 1.5 tablets.

$$\frac{X \text{ tab}}{30 \text{ mg}} = \frac{1 \text{ tab}}{20 \text{ mg}}$$

$$20x = 30 \quad x = 1.5 \text{ tabs}$$

TEST-TAKING HINT: The test taker should set up the ratio and proportion problem based on the number of milligrams contained in 1 tablet and solve this problem by cross multiplication and solving for “X” by division.

60. This client should receive 2 PRN doses. The test taker must recognize that medications are given three times in a 24-hour period when the order reads q8h: $1 \text{ mg} \times 3 = 3 \text{ mg}$. The test taker

must factor in the $0.5 \text{ mg qid} = 2 \text{ mg}$. These two dosages together add up to 5 mg, 1 mg above the maximum daily dose of lorazepam (Ativan). The client would be able to receive only two of the three PRN doses of lorazepam.

TEST-TAKING HINT: To answer this question correctly, the test taker must recognize that the timing of standing medication may affect the decision-making process related to administration of PRN medications. In this case, although the PRN medication is ordered q8h, and could be given three times, the standing medication dosage limits the PRN to two doses, each at least 8 hours apart.