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MULTIPLE CHOICE

1. The patient is a 54-year-old man who has made a living as a construction worker. He dropped out of high school at age 16 and has been a laborer ever since. He never saw any need for "book learning," and has lived his life "my way" since he was a teenager. He has smoked a pack of cigarettes a day for 40 years and follows no special diet, eating a lot of "fast food" while on the job. He now is admitted to the coronary care unit for complaints of chest pain and is scheduled for a cardiac catheterization in the morning. Which of the following would be the best way for the nurse to explain why he needs the procedure?
   a. "The doctor believes that you have atherosclerotic plaques occluding the major arteries in your heart, causing ischemia and possible necrosis of heart tissue."
   b. "There may be a blockage of one of the arteries in your heart, causing the chest discomfort. He needs to know where it is to see how he can treat it."
   c. "We have pamphlets here that can explain everything. Let me get you one."
   d. "It's just like a clogged pipe. All the doctor has to do is 'Roto-Rooter' it to get it cleaned out."

   ANS: B
   To send an accurate message, the sender of verbal communication must be aware of different developmental perspectives as well as cultural differences between sender and receiver, such as the use of dialect or slang.

   DIF: Cognitive Level: Application
   OBJ: Explain the communication process.
   TOP: Verbal Communication
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Psychosocial Integrity

2. The nurse is assessing a patient who says that she is feeling fine. The patient, however, is wringing her hands and is teary eyed. The nurse should respond to the patient in which of the following ways?
   a. "You seem anxious today. Is there anything on your mind?"
   b. "I'm glad you're feeling better. I'll be back later to help you with your bath."
   c. "I can see you're upset. Let me get you some tissue."
   d. "It looks to me like you're in pain. I'll get you some medication."

   ANS: A
   When assessing a patient's needs, assess both the verbal and the nonverbal messages and validate them. In this case, if you see a patient wringing her hands and sighing, it is appropriate to ask, "You seem anxious today. Is there anything on your mind?" It is not enough to accept only the verbal message if nonverbal signals conflict, and it is inappropriate to jump to conclusions about what the nonverbal signals mean.

   DIF: Cognitive Level: Application
   OBJ: Explain the communication process.
   TOP: Nonverbal Communication
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Psychosocial Integrity

3. Nonverbal communication incorporates messages conveyed by:
   a. touch.

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b. cadence.
c. tone quality.
d. use of jargon.

ANS: A
Nonverbal communication describes all behaviors that convey messages without the use of words. This type of communication includes body movement, physical appearance, personal space, and touch. Cadence, tone quality, and the use of jargon are all part of verbal communication.

DIF: Cognitive Level: Knowledge OBJ: Explain the communication process.
TOP: Nonverbal Communication KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

4. The patient is an elderly male who had hip surgery 3 days ago. He states that his hip hurts, but he does not like how the medicine makes him feel. He believes that he can tolerate the pain better than he can tolerate the medication. What would be the best response from the nurse?
a. Explain the need for the pain medication using a slower rate of speech.
b. Explain the need for the pain medication using a simpler vocabulary.
c. Explain the need for the pain medication, but ask the patient if he would like the doctor called and the medication changed.
d. Explain in a loud manner the need for the pain medication.

ANS: C
Suggesting, which is presenting alternative ideas for patient consideration relative to problem solving, can be effective in helping the patient maintain control by increasing the patient's perceived options or choices. Nurses often use elder-speak, which includes a slower rate of speech, greater repetition, and simpler grammar than normal adult speech, when caring for older adults. However, many older patients perceive this type of communication as patronizing.

DIF: Cognitive Level: Application
OBJ: Identify the purpose of therapeutic communication, communication in various phases of the nurse-patient relationship, and special issues related to communication.
TOP: Communication with the Elderly KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

5. When comparing therapeutic communication versus social communication, the professional nurse realizes that therapeutic communication:
a. allows equal opportunity for personal disclosure.
b. allows both participants to have personal needs met.
c. is goal directed and patient centered.
d. provides an opportunity to compare intimate details.

ANS: C
Therapeutic communication empowers patients to make decisions but differs from social communication in that it is patient centered and goal directed with limited disclosure from the professional. Social communication involves equal opportunity for personal disclosure, and both participants seek to have personal needs met. Nurses do not share with patients intimate details of their personal lives.

DIF: Cognitive Level: Application

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OBJ: Develop skills for therapeutic communication in various phases of the nurse-patient relationship. TOP: Establishing the Nurse-Patient Relationship
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

6. The nurse is explaining a procedure to a 2-year-old child. Which is the best approach to use?
   a. Showing the needles and bandages in advance
   b. Telling the patient exactly what discomfort to expect
   c. Using dolls and stories to demonstrate what will be done
   d. Asking the child to draw pictures of what he or she thinks will happen

   ANS: C
   Some age-appropriate communication techniques for a 2-year-old child include storytelling and drawing. Showing the child needles or telling the child about discomfort would increase anxiety. Having a child draw what he expects does not explain what is going to happen.

   DIF: Cognitive Level: Application
   OBJ: Develop skills for therapeutic communication in various phases of the nurse-patient relationship. TOP: Establishing the Nurse-Patient Relationship—Pediatric Considerations
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Psychosocial Integrity

7. The nurse is about to go over the patient's preoperative teaching per hospital protocol. She finds the patient sitting in bed wringing her hands, which are sweaty, and acting slightly agitated. The patient states, "I'm scared that something will go wrong tomorrow." How should the nurse respond?
   a. Redirect her focus to dealing with the patient's anxiety.
   b. Tell the patient that everything will be all right and continue teaching.
   c. Tell the patient that she will return later to do the teaching.
   d. Give the patient antianxiety medication.

   ANS: A
   Anxiety interferes with comprehension, attention, and problem-solving abilities and thus interferes with the patient's care and treatment. To ensure the effectiveness of treatment, the nurse should try to help the patient understand the source of the anxiety. Ignoring the anxiety, medicating for it, and postponing the discussion are all inappropriate.

   DIF: Cognitive Level: Application
   OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Establishing the Nurse-Patient Relationship
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Psychosocial Integrity

8. The nurse is attempting to teach the patient and his family about his care after discharge. The patient and the family demonstrate signs of anxiety during the teaching session. The nurse should consider doing what?
   a. Using more gestures or pictures
   b. Focusing on the physical complaints
   c. Getting another staff member to speak to the patient
   d. Repeating information to the patient and the family at a later time

   ANS: D

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Remember that patients and their family members who are under stress often require repeated explanations. Increasing gestures and pictures is additional stimulation that may increase anxiety. Physical complaints should be acknowledged, but dwelling on them can also increase the patient's anxiety. Involving another staff member would cause a break in the continuity of care.

DIF: Cognitive Level: Application
OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Establishing the Nurse-Patient Relationship
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

9. The patient is an elderly man who was brought to the hospital from an assisted-living community with complaints of anorexia and general malaise. The nurse at the assisted-living community reported that the patient was very ritualistic in his behavior and fastidious in his dress and always took a shower in the evening before bed. The patient became very angry and upset when the patient care technician asked him to take his bath in the morning. What does this behavior tell the nurse?
   a. The patient is exhibiting anxiety because of a change in his rituals.
   b. The patient is suffering from sensory overstimulation.
   c. The patient is basically an angry person.
   d. The patient has to follow hospital protocol.

   ANS: A
   Patients often become ritualistic and intent on performing activities a certain way. Anxiety develops as a result of a specific event or a general pattern of change.

   DIF: Cognitive Level: Analysis
   OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Gerontological Considerations—Anxiety
   KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Psychosocial Integrity

10. The nurse is preparing to give an intramuscular injection to the patient in room 320. The patient care technician comes to the medication room and tells the nurse that the patient in room 316 is very angry with his roommate and is threatening to hit him. How should the nurse respond?
    a. Tell the patient care technician to calm the patient down until she can get there.
    b. Have the angry patient's roommate moved to another location.
    c. Tell the angry patient to calm down until she can get there.
    d. Tell the angry patient that he has to act civilized in the hospital, and that's that.

    ANS: B
    A potentially violent patient needs to be in an environment with decreased stimuli and to have protection from injury to self and against others. Encourage other people, particularly those who provoke anger, to leave the room or area. De-escalation is a skill that cannot be delegated to nursing assistive personnel (NAP).

    DIF: Cognitive Level: Application
    OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Communicating with the Angry Patient
    KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Psychosocial Integrity

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11. Which behavior should the nurse who is communicating with a potentially violent patient employ?
    a. Sit closer to the patient.
    b. Speak loudly and firmly.
    c. Use slow, deliberate gestures.
    d. Always block the door to prevent escape.

    ANS: C
    Make sure that gestures are slow and deliberate rather than sudden and abrupt. There is less chance for misinterpretation of the message, and slow, deliberate gestures are less threatening. Keep an adequate distance between yourself and the patient to reduce your risk of injury and to avoid making the patient feel pressured. Try to talk in a comfortable, reassuring voice. Position yourself closest to the door to facilitate escape from a potentially violent situation. Do not block the exit; if the patient feels unable to escape, this may cause a violent outburst.

    DIF: Cognitive Level: Application
    OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Communicating with the Angry Patient
    KEY: Nursing Process Step: Intervention MSC: NCLEX: Psychosocial Integrity

12. The patient is sitting at the bedside. He has not been eating and is just staring out of the window. The nurse approaches the patient and asks, "What are you thinking about?" What type of communication technique is this?
    a. Restating
    b. Clarification
    c. Broad openings
    d. Reflection

    ANS: C
    Broad openings encourage patients to select topics for discussion. They affirm the value of the patient's initiative. Restating is repeating a main thought that the patient has expressed. Clarification is attempting to put into words vague ideas or asking the patient to explain what he or she means. Reflection is directing back to the patient ideas, feelings, questions, or content.

    DIF: Cognitive Level: Knowledge OBJ: Explain the communication process.
    TOP: Therapeutic Communication Techniques
    KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Psychosocial Integrity

13. A patient tells the nurse, "I want to die." Which response is the most appropriate for the nurse to make?
    a. "Why would you say that?"
    b. "Tell me more about how you are feeling."
    c. "The doctor should be told how you feel."
    d. "You have too much to live for to think that way."

    ANS: B

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Broad openings encourage the patient to select topics for discussion and indicate acceptance by the nurse and the value of the patient's initiative. "Why" questions can cause defensiveness and can hinder communication. Saying you will inform the doctor leads the conversation away from the patient's feelings. Saying the patient has too much to live for is false reassurance and negates the patient's feelings.

DIF: Cognitive Level: Application OBJ: Explain the communication process.
TOP: Therapeutic Communication Techniques
KEY: Nursing Process Step: Intervention MSC: NCLEX: Psychosocial Integrity

14. The patient states, "I don't know what my family will think about this." The nurse wishes to use the communication technique of clarification. Which of the following statements would fit that need best?
    a. "You don't know what your family will think?"
    b. "I'm not sure that I understand what you mean."
    c. "I think it would be helpful if we talk more about your family."
    d. "I sense that you may be anxious about something."

    ANS: B
    The definition of *clarification* is attempting to put into words vague ideas or unclear thoughts of the patient to enhance the nurse's understanding, or asking the patient to explain what he or she means. Repeating main thoughts expressed by patients is known as "restating." Using questions or statements that help patients expand on a topic of importance is known as "focusing." Asking a patient to verify the nurse's understanding of what the patient is thinking or feeling is known as "sharing perceptions."

    DIF: Cognitive Level: Application OBJ: Explain the communication process.
    TOP: Therapeutic Communication Techniques
    KEY: Nursing Process Step: Intervention MSC: NCLEX: Psychosocial Integrity

15. A patient tells the nurse, "I think that I must be really sick. All of these tests are being done." Which response by the nurse uses the specific communication technique of reflection?
    a. "I sense that you are worried."
    b. "I think that we should talk about this more."
    c. "You think that you must be very sick because of all the tests."
    d. "I've noticed that this is an underlying issue whenever we talk."

    ANS: C
    Reflecting is directing back to the patient ideas, feelings, questions, or content, validating the nurse's understanding of what the patient is saying, and signifying empathy, interest, and respect for the patient. Asking the patient to confirm your sense of his or her anxiety is "sharing perceptions." Stating that "we should talk about this more," that is, putting forth questions or statements to expand on a topic, is "focusing." Pointing out underlying issues or problems that occur repeatedly is known as "theme identification."

    DIF: Cognitive Level: Application OBJ: Explain the communication process.
    TOP: Therapeutic Communication Techniques
    KEY: Nursing Process Step: Intervention MSC: NCLEX: Psychosocial Integrity

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16. The patient is admitted to the hospital with complaints of headache, nausea, and dizziness. She states that she has a final exam in the morning and needs to do well on it to pass the course, but she can't seem to get into it. She appears nervous and distracted, and is unable to recall details. She most likely is showing manifestations of _____ anxiety.
    a. mild
    b. moderate
    c. severe
    d. panic state of

    ANS: C
    Severe anxiety manifests as a focus on fragmented details, as well as headache, nausea, dizziness, inability to see connections between details, and poor recall. Mild anxiety manifests as increased auditory and visual perception, increased awareness of relationships, and increased alertness and ability to problem-solve. Moderate anxiety manifests as selective inattention, decreased perceptual field, focus only on relevant information, muscle tension, and diaphoresis. Panic state of anxiety manifests as an inability to notice surroundings, feelings of terror, and inability to cope with any problem.

    DIF: Cognitive Level: Analysis
    OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Manifestations of Anxiety
    KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Physiological Integrity

17. The patient is admitted to the emergency department for trauma received in a fist fight. He states that he could not control himself. He says that his wife left him for another man. He thinks it was because he was always too tired after working to do things. He says he has to work, and there is nothing he could do to change things. He says that he feels trapped in his job, but he knows nothing else. What was the altercation with the other man probably a manifestation of?
    a. Mild anxiety
    b. Depression
    c. Severe anxiety
    d. Moderate anxiety

    ANS: B
    Symptoms of depression include apathy, sadness, sleep disturbances, hopelessness, helplessness, worthlessness, guilt, anger, fatigue, thoughts of death, decreased libido, ruminations of inadequacy, psychomotor agitation, verbal berating of self, spontaneous crying, dependency, and passiveness. Mild anxiety manifests as increased auditory and visual perception, increased awareness of relationships, increased alertness, and an increased ability to problem-solve. Moderate anxiety manifests as selective inattention, decreased perceptual field, focus only on relevant information, muscle tension, and diaphoresis. Severe anxiety manifests as a focus on fragmented details, headache, nausea, dizziness, an inability to see connections between details, and poor recall.

    DIF: Cognitive Level: Analysis
    OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Manifestations of Depression
    KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Psychosocial Integrity

MULTIPLE RESPONSE

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1. Verbal communication includes which of the following? (*Select all that apply.*)
   a. Speech
   b. Personal space
   c. Body movement
   d. Writing

   ANS: A, D
   Verbal communication includes both spoken word and written word. Nonverbal communication describes all behaviors that convey messages without the use of words. This type of communication includes body movement, physical appearance, personal space, and touch.

   DIF: Cognitive Level: Analysis
   OBJ: Explain the communication process.
   TOP: Verbal Communication
   KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Psychosocial Integrity

2. In caring for patients of different cultures, it is important for the nurse to: (*Select all that apply.*)
   a. use appropriate linguistic services.
   b. display empathy and respect.
   c. use accurate health history-taking techniques.
   d. use patient-centered communication.

   ANS: A, B, C, D
   The following factors are essential in providing effective care for culturally and linguistically diverse patients: (1) use of appropriate linguistic services (e.g., interpreter or bilingual health care workers) and/or other communication strategies, (2) display of empathy and respect for culturally and linguistically diverse patients, (3) use of accurate health history-taking techniques for diagnostic and treatment purposes and health teaching, and (4) use of patient-centered communication behaviors, including participatory decision making. It also is helpful to speak plainly and to avoid mimicking a patient's accent or dialect.

   DIF: Cognitive Level: Comprehension
   OBJ: Identify the purpose of therapeutic communication, communication in various phases of the nurse-patient relationship, and special issues related to communication.
   TOP: Cultural Communication
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Psychosocial Integrity

3. The nurse observes that the patient is pacing in his room with clenched fists. When asked "What's wrong?" the patient states, "There's nothing wrong. I just want out of here." He then bangs his fist on the table and yells, "I've had it!" How should the nurse respond? (*Select all that apply.*)
   a. Tell the patient that he needs to calm down.
   b. Pause to collect her own thoughts.
   c. Block the doorway.
   d. Notify the proper authorities.

   ANS: B, D

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Awareness and control of your own reaction and responses will facilitate more constructive interaction. Maintain an open exit. Position yourself closest to the door to facilitate escape from a potentially violent situation. Do not block the exit so the patient feels escape is unattainable; this may cause a violent outburst. An angry patient loses the ability to process information rationally and therefore may impulsively express anger through intimidation. If a strong likelihood of imminent harm to another is present upon discharge, notify the proper authorities (e.g., nurse manager).

DIF: Cognitive Level: Synthesis
OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Communicating with the Angry Patient
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

COMPLETION

1. The nurse is starting her first set of morning rounds. As she interacts with the patient, her questions revolve around his reactions to his disease process. She also asks if there is anything that she can do to make him more comfortable. This type of interaction is known as _____.

   ANS:
   therapeutic communication

   Therapeutic communication is an application of the process of communication to promote the well-being of the patient.

   DIF: Cognitive Level: Analysis
   OBJ: Identify guidelines to use in therapeutic communication. TOP: Therapeutic Communication
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Psychosocial Integrity

2. An active process of receiving information that nonverbally communicates to the patient the nurse's interest and acceptance is classified as _____.

   ANS:
   listening

   Definition: An active process of receiving information and examining one's reaction to messages received. *Therapeutic value:* Nonverbally communicates to the patient the nurse's interest and acceptance.

   DIF: Cognitive Level: Knowledge OBJ: Explain the communication process.
   TOP: Therapeutic Communication Techniques
   KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Psychosocial Integrity

3. The patient is talking about his fear of having surgery but is being vague and is using a lot of jargon. The nurse states, "I'm not sure what you mean. Could you tell me again?" This is an example of _____.

   ANS:

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clarification

Clarification is attempting to put into words vague ideas or unclear thoughts of the patient to enhance the nurse's understanding, or asking the patient to explain what he or she means. This may help to clarify the patient's feelings, ideas, and perceptions, and may provide an explicit correlation between them and the patient's actions.

DIF: Cognitive Level: Application OBJ: Explain the communication process.
TOP: Therapeutic Communication Techniques
KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Psychosocial Integrity

4. Directing the conversation back to patient ideas, feelings, questions, or content is known as _____.

ANS:
reflection

Reflection or directing back to the patient ideas, feelings, questions, or content validates the nurse's understanding of what the patient is saying and signifies empathy, interest, and respect for the patient.

DIF: Cognitive Level: Knowledge OBJ: Explain the communication process.
TOP: Therapeutic Communication Techniques
KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Psychosocial Integrity

5. The patient tells the nurse that his mother left him when he was 5 years old. The nurse responds by saying, "You say that your mother left you when you were 5 years old?" This is an example of _____.

ANS:
restating

Restating is a technique whereby the nurse repeats the main thought that the patient has expressed. It indicates that the nurse is listening, and validates, reinforces, or calls attention to something important that has been said.

DIF: Cognitive Level: Application OBJ: Explain the communication process.
TOP: Therapeutic Communication Techniques
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

6. The patient has been agitated for the entire morning but refuses to say why he is angry. Instead, whenever the nurse speaks to him, he smiles at her while clenching his fist at the same time. The nurse states, "I can see that you're smiling, but I sense that you are really very angry." This is an example of _____.

ANS:
sharing perceptions

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Sharing perceptions is asking the patient to verify the nurse's understanding of what the patient is thinking or feeling. It conveys to the patient the nurse's understanding and has the potential for clearing up confusing communication.

DIF: Cognitive Level: Application OBJ: Explain the communication process.
TOP: Therapeutic Communication Techniques
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

7. Lack of verbal communication for a therapeutic reason is known as _____.

ANS:
therapeutic silence

Lack of verbal communication for a therapeutic reason is known as therapeutic silence. It allows the patient time to think and gain insights, slows the pace of the interaction, and encourages the patient to initiate conversation, while conveying the nurse's support, understanding, and acceptance.

DIF: Cognitive Level: Comprehension OBJ: Explain the communication process.
TOP: Therapeutic Silence KEY: Nursing Process Step: Assessment
MSC: NCLEX: Psychosocial Integrity

8. Anxiety that is the source of inattention, decreased perceptual field, and diaphoresis is classified as _____.

ANS:
moderate anxiety

Moderate anxiety is characterized by selective inattention, decreased perceptual field, the ability to focus only on relevant information, muscle tension, and/or diaphoresis.

DIF: Cognitive Level: Comprehension
OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Anxiety KEY: Nursing Process Step: Diagnosis
MSC: NCLEX: Psychosocial Integrity

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