Psychiatric-Mental Health Nursing 8th edition Videbeck Test Bank

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1. **Chapter 1**.The nurse is assessing the factors contributing to the well-being of a newly admitted client. Which of the following would the nurse identify as having a positive impact on the individual's mental health?
   A) Not needing others for companionship
   B) The ability to effectively manage stress
   C) A family history of mental illness
   D) Striving for total self-reliance
   Ans: B
   Feedback:
   Individual factors influencing mental health include biologic makeup, autonomy, independence, self-esteem, capacity for growth, vitality, ability to find meaning in life, emotional resilience or hardiness, sense of belonging, reality orientation, and coping or stress management abilities. Interpersonal factors such as intimacy and a balance of separateness and connectedness are both needed for good mental health, and therefore a healthy person would need others for companionship. A family history of mental illness could relate to the biologic makeup of an individual, which may have a negative impact on an individual's mental health, as well as a negative impact on an individual's interpersonal and socialñcultural factors of health. Total self-reliance is not possible, and a positive social/cultural factor is access to adequate resources.

2. Which of the following statements about mental illness are true? Select all that apply.
   A) Mental illness can cause significant distress, impaired functioning, or both.
   B) Mental illness is only due to social/cultural factors.
   C) Social/cultural factors that relate to mental illness include excessive dependency on or withdrawal from relationships.
   D) Individuals suffering from mental illness are usually able to cope effectively with daily life.
   E) Individuals suffering from mental illness may experience dissatisfaction with relationships and self.
   Ans: A, D, E
   Feedback:
   Mental illness can cause significant distress, impaired functioning, or both. Mental illness may be related to individual, interpersonal, or social/cultural factors. Excessive dependency on or withdrawal from relationships are interpersonal factors that relate to mental illness. Individuals suffering from mental illness can feel overwhelmed with daily life. Individuals suffering from mental illness may experience dissatisfaction with relationships and self.

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3. Which of the following are true regarding mental health and mental illness?
   A) Behavior that may be viewed as acceptable in one culture is always unacceptable in other cultures.
   B) It is easy to determine if a person is mentally healthy or mentally ill.
   C) In most cases, mental health is a state of emotional, psychological, and social wellness evidenced by satisfying interpersonal relationships, effective behavior and coping, positive self-concept, and emotional stability.
   D) Persons who engage in fantasies are mentally ill.
   Ans: C
   Feedback:
   What one society may view as acceptable and appropriate behavior, another society may see that as maladaptive, and inappropriate. Mental health and mental illness are difficult to define precisely. In most cases, mental health is a state of emotional, psychological, and social wellness evidenced by satisfying interpersonal relationships, effective behavior and coping, positive self-concept, and emotional stability. Persons who engage in fantasies may be mentally healthy, but the inability to distinguish reality from fantasy is an individual factor that may contribute to mental illness.

4. A client grieving the recent loss of her husband asks if she is becoming mentally ill because she is so sad. The nurse's best response would be,
   A) ìYou may have a temporary mental illness because you are experiencing so much pain.î
   B) ìYou are not mentally ill. This is an expected reaction to the loss you have experienced.î
   C) ìWere you generally dissatisfied with your relationship before your husband's death?î
   D) ìTry not to worry about that right now. You never know what the future brings.î
   Ans: B
   Feedback:
   Mental illness includes general dissatisfaction with self, ineffective relationships, ineffective coping, and lack of personal growth. Additionally the behavior must not be culturally expected. Acute grief reactions are expected and therefore not considered mental illness. False reassurance or overanalysis does not accurately address the client's concerns.

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5. The nurse consults the DSM for which of the following purposes?
   A) To devise a plan of care for a newly admitted client
   B) To predict the client's prognosis of treatment outcomes
   C) To document the appropriate diagnostic code in the client's medical record
   D) To serve as a guide for client assessment
   Ans: D
   Feedback:
   The DSM provides standard nomenclature, presents defining characteristics, and identifies underlying causes of mental disorders. It does not provide care plans or prognostic outcomes of treatment. Diagnosis of mental illness is not within the generalist RN's scope of practice, so documenting the code in the medical record would be inappropriate.

6. Which would be a reason for a student nurse to use the DSM?
   A) Identifying the medical diagnosis
   B) Treat clients
   C) Evaluate treatments
   D) Understand the reason for the admission and the nature of psychiatric illnesses.
   Ans: D
   Feedback:
   Although student nurses do not use the DSM to diagnose clients, they will find it a helpful resource to understand the reason for the admission and to begin building knowledge about the nature of psychiatric illnesses. Identifying the medical diagnosis, treating, and evaluating treatments are not a part of the nursing process.

7. The legislation enacted in 1963 was largely responsible for which of the following shifts in care for the mentally ill?
   A) The widespread use of community-based services
   B) The advancement in pharmacotherapies
   C) Increased access to hospitalization
   D) Improved rights for clients in long-term institutional care
   Ans: A
   Feedback:
   The Community Mental Health Centers Construction Act of 1963 accomplished the release of individuals from long-term stays in state institutions, the decrease in admissions to hospitals, and the development of community-based services as an alternative to hospital care.

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8. Which one of the following is a result of federal legislation?
   A) Making it easier to commit people for mental health treatment against their will.
   B) Making it more difficult to commit people for mental health treatment against their will.
   C) State mental institutions being the primary source of care for mentally ill persons.
   D) Improved care for mentally ill persons.
   Ans: B
   Feedback:
   Commitment laws changed in the early 1970s, making it more difficult to commit people for mental health treatment against their will. Deinstitutionalization accomplished the release of individuals from long-term stays in state institutions. Deinstitutionalization also had negative effects in that some mentally ill persons are subjected to the revolving door effect, which may limit care for mentally ill persons.

9. The goal of the 1963 Community Mental Health Centers Act was to
   A) ensure patients' rights for the mentally ill.
   B) deinstitutionalize state hospitals.
   C) provide funds to build hospitals with psychiatric units.
   D) treat people with mental illness in a humane fashion.
   Ans: B
   Feedback:
   The 1963 Community Mental Health Centers Act intimated the movement toward treating those with mental illness in a less restrictive environment. This legislation resulted in the shift of clients with mental illness from large state institutions to care based in the community. Answer choices A, C, and D were not purposes of the 1963 Community Mental Health Centers Act.

10. The creation of asylums during the 1800s was meant to
    A) improve treatment of mental disorders.
    B) provide food and shelter for the mentally ill.
    C) punish people with mental illness who were believed to be possessed.
    D) remove dangerous people with mental illness from the community.
    Ans: B
    Feedback:
    The asylum was meant to be a safe haven with food, shelter, and humane treatment for the mentally ill. Asylums were not used to improve treatment of mental disorders or to punish mentally ill people who were believed to be possessed. The asylum was not created to remove the dangerously mentally ill from the community.

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11. The major problems with large state institutions are: Select all that apply.
    A) attendants were accused of abusing the residents.
    B) stigma associated with residence in an insane asylum.
    C) clients were geographically isolated from family and community.
    D) increasing financial costs to individual residents.
    Ans: A, C
    Feedback:
    Clients were often far removed from the local community, family, and friends because state institutions were usually in rural or remote settings. Choices B and D were not major problems associated with large state instructions.

12. A significant change in the treatment of people with mental illness occurred in the 1950s when
    A) community support services were established.
    B) legislation dramatically changed civil commitment procedures.
    C) the Patient's Bill of Rights was enacted.
    D) psychotropic drugs became available for use.
    Ans: D
    Feedback:
    The development of psychotropic drugs, or drugs used to treat mental illness, began in the 1950s. Answer choices A, B, and C did not occur in the 1950s.

13. Before the period of the enlightenment, treatment of the mentally ill included
    A) creating large institutions to provide custodial care.
    B) focusing on religious education to improve their souls.
    C) placing the mentally ill on display for the public's amusement.
    D) providing a safe refuge or haven offering protection.
    Ans: C
    Feedback:
    In 1775, visitors at St. Mary's of Bethlehem were charged a fee for viewing and ridiculing the mentally ill, who were seen as animals, less than human. Custodial care was not often provided as persons who were considered harmless were allowed to wander in the countryside or live in rural communities, and more dangerous lunatics were imprisoned, chained, and starved. In early Christian times, primitive beliefs and superstitions were strong. The mentally ill were viewed as evil or possessed. Priests performed exorcisms to rid evil spirits, and in the colonies, witch hunts were conducted with offenders burned at the stake. It was not until the period of enlightenment when persons who were mentally ill were offered asylum as a safe refuge or haven offering protection at institutions.

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14. The first training of nurses to work with persons with mental illness was in 1882 in which state?
    A) California
    B) Illinois
    C) Massachusetts
    D) New York
    Ans: C
    Feedback:
    The first training for nurses to work with persons with mental illness was in 1882 at McLean Hospital in Belmont, Massachusetts.

15. What is meant by the term ìrevolving door effectî in mental health care?
    A) An overall reduction in incidence of severe mental illness
    B) Shorter and more frequent hospital stays for persons with severe and persistent mental illness
    C) Flexible treatment settings for mentally ill
    D) Most effective and least expensive treatment settings
    Ans: B
    Feedback:
    The revolving door effect refers to shorter, but more frequent, hospital stays. Clients are quickly discharged into the community where services are not adequate; without adequate community services, clients become acutely ill and require rehospitalization. The revolving door effect does not refer to flexible treatment settings for mentally ill. Even though hospitalization is more expensive than outpatient treatment, if utilized appropriately could result in stabilization and less need for emergency department visits and/or rehospitalization. The revolving door effect does not relate to the incidence of severe mental illness.

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16. Which of the following statements is true of treatment of people with mental illness in the United States today?
    A) Substance abuse is effectively treated with brief hospitalization.
    B) Financial resources are reallocated from state hospitals to community programs and support.
    C) Only 25% of people needing mental health services are receiving those services.
    D) Emergency department visits by persons who are acutely disturbed are declining.
    Ans: C
    Feedback:
    Only one in four (25%) adults needing mental health care receives the needed services. Substance abuse issues cannot be dealt with in the 3 to 5 days typical for admissions in the current managed care environment. Money saved by states when state hospitals were closed has not been transferred to community programs and support. Although people with severe and persistent mental illness have shorter hospital stays, they are admitted to hospitals more frequently. In some cities, emergency department visits for acutely disturbed persons have increased by 400% to 500%.

17. Which of the following is the priority of the Healthy People 2020 objectives for mental health?
    A) Improved inpatient care
    B) Primary prevention of emotional problems
    C) Stress reduction and management
    D) Treatment of mental illness
    Ans: D
    Feedback:
    The objectives are to increase the number of people who are identified, diagnosed, treated, and helped to live healthier lives. The objectives also strive to decrease rates of suicide and homelessness, to increase employment among those with serious mental illness, and to provide more services both for juveniles and for adults who are incarcerated and have mental health problems. Answer choices A, B, and C are not priorities of Healthy People 2020.

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18. Which is a positive aspect of treating clients with mental illness in a community-based care?
    A) ìYou will not be allowed to go out with your friends while in the program.î
    B) ìYou will have to have supervision when you want to go anywhere else in the community.î
    C) ìYou will be able to live in your own home while you still see a therapist regularly.î
    D) ìYou will have someone in your home at all times to ask questions if you have any concerns.î
    Ans: C
    Feedback:
    Clients can remain in their communities, maintain contact with family and friends, and enjoy personal freedom that is not possible in an institution. Full-time home care is not included in community-based programs.

19. One of the unforeseen effects of the movement toward community mental health services is
    A) fewer clients suffering from persistent mental illnesses.
    B) an increased number of hospital beds available for clients seeking treatment.
    C) an increased number of admissions to available hospital services.
    D) Longer hospital stays for people needing mental health services.
    Ans: C
    Feedback:
    Although people with severe and persistent mental illness have shorter hospital stays, they are admitted to hospitals more frequently. Although deinstitutionalization reduced the number of public hospital beds by 80%, the number of admissions to those beds correspondingly increased by 90%. The number of individuals with mental illness did not change.

20. Which is included in Healthy People 2020 objectives?
    A) To decrease the incidence of mental illness
    B) To increase the number of people who are identified, diagnosed, treated, and helped to live healthier lives
    C) To provide mental health services only in the community
    D) To decrease the numbers of people who are being treated for mental illness
    Ans: B
    Feedback:
    One of the Healthy People 2020 objectives is to increase the number of people who are identified, diagnosed, treated, and helped to live healthier lives. It may not be possible to decrease the incidence of mental illness. At this time, the focus is on ensuring that persons with mental illness are receiving needed treatment. It may not be possible or desirable to provide mental health services only in the community.

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21. A client diagnosed with a mild anxiety disorder has been referred to treatment in a community mental health center. Treatment most likely provided at the center includes
    A) medical management of symptoms.
    B) daily psychotherapy.
    C) constant staff supervision.
    D) psychological stabilization.
    Ans: A
    Feedback:
    Community mental health centers focus on rehabilitation, vocational needs, education, and socialization, as well as on management of symptoms and medication. Daily therapies, constant supervision, and stabilization require a more acute care inpatient setting.

22. Which of the following is defined as an advanced-level function in the practice area of psychiatric mental health nursing?
    A) Case management
    B) Counseling
    C) Evaluation
    D) Health teaching
    Ans: C
    Feedback:
    Advanced-level functions are psychotherapy, prescriptive authority, consultation and liaison, evaluation, and program development and management. Case management, counseling, and health teaching are basic-level functions in the practice area of psychiatric mental health nursing.

23. Psychiatric nursing became a requirement in nursing education in which year?
    A) 1930
    B) 1940
    C) 1950
    D) 1960
    Ans: C
    Feedback:
    It was not until 1950 that the National League for Nursing, which accredits nursing programs, required schools to include an experience in psychiatric nursing.

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24. A new graduate nurse has accepted a staff position at an inpatient mental health facility. The graduate nurse can expect to be responsible for basic-level functions, including
    A) providing clinical supervision.
    B) using effective communication skills.
    C) adjusting client medications.
    D) directing program development.
    Ans: B
    Feedback:
    Basic-level functions include counseling, milieu therapy, self-care activities, psychobiologic interventions, health teaching, case management, and health promotion and maintenance. Advanced-level functions include psychotherapy, prescriptive authority for drugs, consultation and liaison, evaluation, program development and management, and clinical supervision.

25. Which one of the following is one of the American Nurses Association standards of practice for psychiatricñmental health nursing?
    A) Prescriptive authority is granted to psychiatricñmental health registered nurses.
    B) All aspects of Standard 5: Implementation may be carried out by psychiatricñmental health registered nurses.
    C) Some aspects of Standard 5: Implementation may only be carried out by psychiatricñmental health advanced practice nurses.
    D) Psychiatricñmental health advanced practice nurses are the only ones who may provide milieu therapy.
    Ans: C
    Feedback:
    Prescriptive authority is used by psychiatricñmental health *advanced practice* registered nurses in accordance with state and federal laws and regulations. Standards $5_{DñG}$ are advanced practice interventions and may be performed only by the psychiatricñmental health advanced practice registered nurse. Psychiatricñmental health registered nurses may provide milieu therapy according to Standard 5_C. This is not restricted to psychiatricñmental health advanced practice nurses.

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26. Which of the following is a standard of professional performance?
    A) Assessment
    B) Education
    C) Planning
    D) Implementation
    Ans: B
    Feedback:
    Education is a standard of professional performance. Other standards of professional performance include the quality of practice, professional practice evaluation, collegiality, collaboration, ethics, research, resource utilization, and leadership. Assessment, planning, and implementation are components of the nursing process, not standards of professional performance.

27. Which of the following is a standard of practice?
    A) Quality of care
    B) Outcome identification
    C) Collegiality
    D) Performance appraisal
    Ans: B
    Feedback:
    Standards of practice include assessment, diagnosis, outcomes identification, planning, implementation, coordination of care, health teaching and health promotion, and milieu therapy. The standards of professional performance include quality of practice, education, professional practice evaluation, collegiality, collaboration, ethics, research, resource utilization, and leadership.

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28. A student appears very nervous on the first day of clinical in a psychiatric setting. The student reviews the instructor's guidelines and appropriately takes which of the following actions? Select all that apply.
    A) Tells the client about personal events and interests
    B) Discusses the anxious feelings with the instructor
    C) Assumes that the client's unwillingness to talk to a student nurse is a personal insult or failure
    D) Builds rapport with the patient before asking personal questions
    E) Consults the instructor if a shocking situation arises
    F) Gravitates to clients that the student may know personally
    Ans: B, D, E
    Feedback:
    Listening carefully, showing genuine interest, and caring about the client are extremely important rather than speaking about oneself. The student must deal with his or her own anxiety about approaching a stranger to talk about very sensitive and personal issues. Student nurses should not see the client's unwillingness to talk to a student nurse as a personal insult or behavior. Being available and willing to listen are often all it takes to begin a significant interaction with someone. Questions involving personal matters should not be the first thing a student says to the client. These issues usually arise after some trust and rapport have been established. The nursing instructor and staff are always available to assist if the client is shocking or distressing to the student. If the student recognizes someone he or she knows, it is usually best for the student to talk with the client and reassure him or her about confidentiality. The client should be reassured that the student will not read the client's record and will not be assigned to work with the client.

29. The appropriate action for a student nurse who says the wrong thing is to
    A) pretend that the student nurse did not say it.
    B) restate it by saying, ìThat didn't come out right. What I meant was...î
    C) state that it was a joke.
    D) ignore the error, since no one is perfect.
    Ans: B
    Feedback:
    No one magic phrase can solve a client's problems; likewise, no single statement can significantly worsen them. Listening carefully, showing genuine interest, and caring about the client are extremely important. A nurse who possesses these elements but says something that sounds out of place can simply restate it by saying, ìThat didn't come out right. What I meant wasÖî Pretending that the student nurse did not say it, stating that it was a joke, and ignoring the error are not likely to help the student nurse build and maintain credibility with the client.

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1. **Chapter 2**.The nurse is assessing a patient suffering a head injury as a result of an altercation with two other individuals. The patient has difficulty accurately reporting the events of the altercation and appears very emotional during the assessment. The nurse suspects which part of the brain received the greatest amount of injury?
   A) Cerebrum
   B) Cerebellum
   C) Medulla
   D) Amygdala
   Ans: A
   Feedback:
   The frontal lobes of the cerebrum control the organization of thought, body movement, memories, emotions, and moral behavior. The cerebellum is located below the cerebrum and is the center for coordination of movements and postural adjustments. The medulla, located at the top of the spinal cord, contains vital centers for respiration and cardiovascular functions. The hippocampus and amygdala are involved in emotional arousal and memory.

2. An abnormality of which of the following structures of the cerebrum would be associated with schizophrenia?
   A) Parietal lobes
   B) Frontal lobe
   C) Occipital lobe
   D) Temporal lobes
   Ans: B
   Feedback:
   Abnormalities in the frontal lobes are associated with schizophrenia, attention deficit hyperactivity disorder (ADHD), and dementia. The parietal lobes interpret sensations of taste and touch and assist in spatial orientation. The temporal lobes are centers for the senses of smell and hearing and for memory and emotional expression. The occipital lobe assists in coordinating language generation and visual interpretation, such as depth perception.

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3. A patient with bipolar disorder asks the nurse, ìWhy did I get this illness? I don't want to be sick.î The nurse would best respond with,
   A) ìPeople who develop mental illnesses often had very traumatic childhood experiences.î
   B) ìThere is some evidence that contracting a virus during childhood can lead to mental disorders.î
   C) ìSometimes people with mental illness have an overactive immune system.î
   D) ìWe don't fully understand the cause, but mental illnesses do seem to run in families.î
   Ans: D
   Feedback:
   Current theories and studies indicate that several mental disorders may be linked to a specific gene or combination of genes, but that the source is not solely genetic; nongenetic factors also play important roles. A compromised immune system could contribute to the development of a variety of illnesses, particularly in populations already genetically at risk. Maternal exposure to a virus during critical fetal development of the nervous system may contribute to mental illness.

4. Which of the following statements about the neurobiologic causes of mental illness is most accurate?
   A) Genetics and heredity can explain all causes of mental illness.
   B) Viral infection has been proven to be the cause of schizophrenia.
   C) There is no evidence that the immune system is related to mental illness.
   D) Several mental disorders may be linked to genetic and nongenetic factors.
   Ans: D
   Feedback:
   Current theories and studies indicate that several mental disorders may be linked to a specific gene or combination of genes, but that the source is not solely genetic; nongenetic factors also play important roles. Most studies involving viral theories have focused on schizophrenia, but so far none has provided specific or conclusive evidence. A compromised immune system could contribute to the development of a variety of illnesses, particularly in populations already genetically at risk. So far, efforts to link a specific stressor with a specific disease have been unsuccessful. When the inflammatory response is critically involved in illnesses such as multiple sclerosis or lupus erythematosus, mood dysregulation and even depression are common.

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5. Which of the following is an inhibitory neurotransmitter?
   A) Dopamine
   B) GABA
   C) Norepinephrine
   D) Epinephrine
   Ans: B
   Feedback:
   GABA is the major inhibitory neurotransmitter in the brain and has been found to modulate other neurotransmitter systems rather than to provide a direct stimulus. Dopamine, norepinephrine, and epinephrine are excitatory neurotransmitters.

6. Which of the following is a neuromodulator?
   A) Neuropeptides
   B) Glutamate
   C) Dopamine
   D) GABA
   Ans: A
   Feedback:
   Neuropeptides are neuromodulators. Glutamate and dopamine are excitatory neurotransmitters. GABA is an inhibitory neurotransmitter.

7. A nurse is leading a medication education group for patients with depression. A patient states he has read that herbal treatments are just as effective as prescription medications. The best response is,
   A) ìWhen studies are published they can be trusted to be accurate.î
   B) ìWe need to look at the research very closely to see how reliable the studies are.î
   C) ìYour prescribed medication is the best for your condition, so you should not read those studies.î
   D) ìSwitching medications will alter the course of your illness. It is not advised.î
   Ans: B
   Feedback:
   Often, reports in the media regarding new research and studies are confusing, contradictory, or difficult for clients and their families to understand. The nurse must ensure that clients and families are well informed about progress in these areas and must also help them to distinguish between facts and hypotheses. The nurse can explain if or how new research may affect a client's treatment or prognosis. The nurse is a good resource for providing information and answering questions.

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8. The nurse is preparing a patient for an MRI scan of the head. The nurse should ask the patient,
   A) ìHave you ever had an allergic reaction to radioactive dye?î
   B) ìHave you had anything to eat in the last 24 hours?î
   C) ìDoes your insurance cover the cost of this scan?î
   D) ìAre you anxious about being in tight spaces?î
   Ans: D
   Feedback:
   The person undergoing an MRI must lie in a small, closed chamber and remain motionless during the procedure, which takes about 45 minutes. Those who feel claustrophobic or have increased anxiety may require sedation before the procedure. PET scans require radioactive substances to be injected into the bloodstream. A patient is not required to fast before brain imaging studies. Verifying insurance benefits is not a primary role of the nurse.

9. How should the nurse respond to a family member who asks how Alzheimer's disease is diagnosed?
   A) It is impossible to know for certain that a person has Alzheimer's disease until the person dies and his or her brain can be examined via autopsy.
   B) Positron emission tomography (PET) scans can identify the amyloid plaques and tangles of Alzheimer's disease in living clients.
   C) Alzheimer's disease can be diagnosed by using chemical markers that demonstrate decreased cerebral blood flow.
   D) It will be necessary for the patient to undergo positron emission tomography (PET) scans regularly for a long period of time to know if the patient has Alzheimer's disease.
   Ans: B
   Feedback:
   Positron emission tomography (PET) scans can identify the amyloid plaques and tangles of Alzheimer's disease in living clients. These conditions previously could be diagnosed only through autopsy. Some persons with schizophrenia also demonstrate decreased cerebral blood flow. A limitation of PET scans is that the use of radioactive substances limits the number of times a person can undergo these tests.

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10. A patient is being seen in the crisis unit reporting that poison letters are coming in the mail. The patient has no history of psychiatric illness. Which of the following medications would the patient most likely be started on?
    A) Aripiprazole (Abilify)
    B) Risperidone (Risperdal Consta)
    C) Fluphenazine (Prolixin)
    D) Fluoxetine (Prozac)
    Ans: A
    Feedback:
    New-generation antipsychotics are preferred over conventional antipsychotics because they control symptoms without some of the side effects. Injectable antipsychotics, such as Risperdal Consta, are indicated after the client's condition is stabilized with oral doses of these medications. Prozac is an antidepressant and is not indicated to relieve of psychotic symptoms.

11. Which one of the following types of antipsychotic medications is most likely to produce extrapyramidal effects?
    A) Atypical antipsychotic drugs
    B) First-generation antipsychotic drugs
    C) Third-generation antipsychotic drugs
    D) Dopamine system stabilizers
    Ans: B
    Feedback:
    The conventional, or first-generation, antipsychotic drugs are potent antagonists of D2, D3, and D4. This makes them effective in treating target symptoms but also produces many extrapyramidal side effects because of the blocking of the D2 receptors. Newer, atypical or second-generation antipsychotic drugs are relatively weak blockers of D2, which may account for the lower incidence of extrapyramidal side effects. The third generation of antipsychotics, called dopamine system stabilizers, is being developed. These drugs are thought to stabilize dopamine output that results in control of symptoms without some of the side effects of other antipsychotic medications.

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12. A patient with schizophrenia is being treated with olanzapine (Zyprexa) 10 mg. daily. The patient asks the nurse how this medicine works. The nurse explains that the mechanism by which the olanzapine controls the patient's psychotic symptoms is believed to be
    A) increasing the amount of serotonin and norepinephrine in the brain.
    B) decreasing the amount of an enzyme that breaks down neurotransmitters.
    C) normalizing the levels of serotonin, norepinephrine, and dopamine.
    D) blocking dopamine receptors in the brain.
    Ans: D
    Feedback:
    The major action of all antipsychotics in the nervous system is to block receptors for the neurotransmitter dopamine. SSRIs and TCSs act by blocking the reuptake of serotonin and norepinephrine. MAOIs prevent the breakdown of MAO, an enzyme that breaks down neurotransmitters. Lithium normalizes the reuptake of certain neurotransmitters such as serotonin, norepinephrine, acetylcholine, and dopamine.

13. A patient with depression has been taking paroxetine (Paxil) for the last 3 months and has noticed improvement of symptoms. Which of the following side effects would the nurse expect the patient to report?
    A) A headache after eating wine and cheese
    B) A decrease in sexual pleasure during intimacy
    C) An intense need to move about
    D) Persistent runny nose
    Ans: B
    Feedback:
    Sexual dysfunction can result from enhanced serotonin transmission associated with SSRI use. Headache caused by hypertension can result when combining MAOIs with foods containing tyramine, such as aged cheeses and alcoholic beverages. SSRIs cause less weight gain than other antidepressants. Dry mouth and nasal passages are common anticholinergic side effects associated with all antidepressants. An intense need to move about (akathisia) is an extrapyramidal side effect that would be expected of an antipsychotic medication. Furthermore, sedation is a common side effect of Paxil.

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14. Which one of the following drugs should the nurse expect the patient to require serum level monitoring?
    A) Anticonvulsants
    B) Wellbutrin
    C) Lithium
    D) Prozac
    Ans: C
    Feedback:
    Toxicity is closely related to serum lithium levels and can occur at therapeutic doses. For clients taking lithium and the anticonvulsants, monitoring blood levels periodically is important.

15. Which of the following disorders are extrapyramidal symptoms that may be caused by antipsychotic drugs? Select all that apply.
    A) Akathisia
    B) Pseudoparkinsonism
    C) Neuroleptic malignant syndrome
    D) Dystonia
    E) Anticholinergic effects
    F) Breast tenderness in men and women
    Ans: A, B, D
    Feedback:
    Extrapyramidal symptoms include dystonia, pseudoparkinsonism, and akathisia. Neuroleptic malignant syndrome is also a side effect of antipsychotic drugs but is an idiosyncratic reaction to an antipsychotic drug, not an extrapyramidal symptom. Breast tenderness in men and women is also a potential side effect of antipsychotic drugs that cause elevated prolactin levels, but it is not an extrapyramidal symptom.

16. Which of the following antidepressant drugs is a preferred drug for clients at high risk of suicide?
    A) Tranylcypromine (Parnate)
    B) Sertraline (Zoloft)
    C) Imipramine (Tofranil)
    D) Phenelzine (Nardil)
    Ans: B
    Feedback:
    SSRIs, venlafaxine, nefazodone, and bupropion are often better choices for those who are potentially suicidal or highly impulsive because they carry no risk of lethal overdose, in contrast to the cyclic compounds and the MAOIs. Parnate and Nardil are MAOIs. Tofranil is a cyclic compound.

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17. The nurse knows that the client understands the rationale for dietary restrictions when taking MAOI when the client makes which of the following statements?
    A) ìI am now allergic to foods that are high in the amino acid tyramine such as aged cheese, organ meats, wine, and chocolate.î
    B) ìCertain foods will cause me to have sexual dysfunction when I take this medication.î
    C) ìFoods that are high in tyramine will reduce the medication's effectiveness.î
    D) ìI should avoid foods that are high in the amino acid tyramine such as aged cheese, meats, and chocolate because this drug causes the level of tyramine to go up to dangerous levels.î

    Ans: D

    Feedback:

    Because the enzyme MAO is necessary to break down the tyramine in certain foods, its inhibition results in increased serum tyramine levels, causing severe, hypertension, hyperpyrexia, tachycardia, diaphoresis, tremulousness, and cardiac dysrhythmias. Taking an MAOI does not confer allergy to tyramine. Sexual dysfunction is a common side effect of MAOIs. There is no evidence that foods high in tyramine will increase sexual dysfunction or reduce the medication's effectiveness.

18. A client who is taking paroxetine (Paxil) reports to the nurse that he has been nauseated since beginning the medication. Which of the following actions is indicated initially?
    A) Instruct the client to stop the medication for a few days to see if the nausea goes away.
    B) Reassure the client that this is an expected side effect that will improve with time.
    C) Suggest that the client take the medication with food.
    D) Tell the client to contact the physician for a change in medication.

    Ans: C

    Feedback:

    Taking selective serotonin reuptake inhibitors with food usually eliminates nausea. There is a delayed therapeutic response to antidepressants. The client should not stop taking the drug. It would be appropriate to reassure the client that this is an expected side effect that will improve with time, but that would not be done initially. A change in medication may be indicated if the nausea is intolerable or persistent, but that would not be done initially.

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19. In planning for a client's discharge, the nurse must know that the most serious risk for the client taking a tricyclic antidepressant is which of the following?
    A) Hypotension
    B) Narrow-angle glaucoma
    C) Seizures
    D) Suicide by overdose
    Ans: D
    Feedback:
    Cyclic antidepressants (including tricyclic antidepressants) are potentially lethal if taken in an overdose. The cyclic antidepressants block cholinergic receptors, resulting in anticholinergic effects such as dry mouth, constipation, urinary hesitancy or retention, dry nasal passages, and blurred near vision. More severe anticholinergic effects such as agitation, delirium, and ileus may occur, particularly in older adults. Other common side effects include orthostatic hypotension, sedation, weight gain, and tachycardia. Clients may develop tolerance to anticholinergic effects (such as orthostatic hypotension and worsening of narrow-angle glaucoma, but these side effects are common reasons that clients discontinue drug therapy. The risk of seizures is increased by bupropion, which is a different type of antidepressant.

20. A client with severe and persistent mental illness has been taking antipsychotic medication for 20 years. The nurse observes that the client's behavior includes repetitive movements of the mouth and tongue, facial grimacing, and rocking back and forth. The nurse recognizes these behaviors as indicative of
    A) extrapyramidal side effects
    B) loss of voluntary muscle control
    C) posturing
    D) tardive dyskinesia
    Ans: D
    Feedback:
    The client's behaviors are classic signs of tardive dyskinesia. Tardive dyskinesia, a syndrome of permanent involuntary movements, is most commonly caused by the long-term use of conventional antipsychotic drugs. Extrapyramidal side effects are reversible movement disorders induced by antipsychotic or neuroleptic medication. The client's behavior is not a loss of voluntary control or posturing.

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21. A client is seen in the clinic with clinical manifestations of an inability to sit still and a rigid posture. These side effects would be correctly identified as which of the following?
    A) Tardive dyskinesia
    B) Neuroleptic malignant syndrome
    C) Dystonia
    D) Akathisia
    Ans: D
    Feedback:
    Akathisia is reported by the client as an intense need to move about. The client appears restless or anxious and agitated, often with a rigid posture or gain and a lack of spontaneous gestures. The symptoms of tardive dyskinesia (TD) include involuntary movements of the tongue, facial and neck muscles, upper and lower extremities, and truncal musculature. Tongue thrusting and protruding, lip smacking, blinking, grimacing, and other excessive unnecessary facial movements are characteristic. Neuroleptic malignant syndrome is a potentially fatal reaction manifested by rigidity, high fever, and autonomic instability. Acute dystonia includes acute muscular rigidity and cramping, a stiff or thick tongue with difficulty swallowing, and, in severe cases, laryngospasm and respiratory difficulties.

22. Which of the following is a term used to describe the occurrence of the eye rolling back in a locked position, which occurs with acute dystonia?
    A) Opisthotonus
    B) Oculogyric crisis
    C) Torticollis
    D) Pseudoparkinsonism
    Ans: B
    Feedback:
    Oculogyric crisis is the occurrence of the eye rolling back in a locked position, which occurs with acute dystonia. Opisthotonus is tightness in the entire body with the head back and an arched neck. Torticollis is twisted head and neck. Oculogyric crisis, opisthotonus, and torticollis are manifestations of acute dystonia. Pseudoparkinsonism is drug-induced parkinsonism and is often referred to by the generic label of extrapyramidal side effects.

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23. Which of the following medications rarely causes extrapyramidal side effects (EPS)?
    A) Ziprasidone (Geodon)
    B) Chlorpromazine (Thorazine)
    C) Haloperidol (Haldol)
    D) Fluphenazine (Prolixin)
    Ans: A
    Feedback:
    First-generation antipsychotic drugs cause a greater incidence of EPS than do atypical antipsychotic drugs, with ziprasidone (Geodon) rarely causing EPS. Thorazine, Haldol, and Prolixin are all first-generation antipsychotic drugs.

24. Which of the following increases the risk for neuroleptic malignant syndrome (NMS)?
    A) Overhydration
    B) Intake of vitamins
    C) Dehydration
    D) Vegetarian diet
    Ans: C
    Feedback:
    Dehydration, poor nutrition, and concurrent medical illness all increase the risk for NMS. Overhydration is opposite of dehydration and would therefore not increase the risk of NMS. Intake of vitamins would likely reduce the risk of NMS as it would improve nutritional status. Vegetarian diet would not relate to NMS.

25. Which of the following was the first nonstimulant medication specifically designed and tested for ADHD?
    A) Methylphenidate (Ritalin)
    B) Amphetamine (Adderall)
    C) Atomoxetine (Strattera)
    D) Pemoline (Cylert)
    Ans: C
    Feedback:
    Strattera was the first nonstimulant medication specifically designed and tested for ADHD. The primary stimulant drugs used to treat ADHD are methylphenidate (Ritalin), amphetamine (Adderall), and pemoline (Cylert).

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26. Which of the following is the primary consideration with clients taking antidepressants?
    A) Decreased mobility
    B) Emotional changes
    C) Suicide
    D) Increased sleep
    Ans: C
    Feedback:
    Suicide is always a primary consideration when treating clients with depression.

27. Which of the following would not be included as a symptom of drug-induced parkinsonism?
    A) Stooped posture
    B) Cogwheel rigidity
    C) Drooling
    D) Tachycardia
    Ans: D
    Feedback:
    Bradycardia (not tachycardia), a stooped posture, cogwheel rigidity, and drooling are all symptoms of pseudoparkinsonism. Other symptoms of pseudoparkinsonism include mask-like facies, decreased arm swing, a shuffling, festinating gait, tremor, and coarse pill-rolling movements of the thumb and fingers while at rest.

28. Which drug classification is the primary medication treatment for schizophrenia?
    A) Anticoagulants
    B) Antidepressants
    C) Antimanics
    D) Antipsychotics
    Ans: D
    Feedback:
    Antipsychotic drugs are the primary medical treatment for clients diagnosed with schizophrenia and are also used in psychotic episodes of acute mania, psychotic depression, and drug-induced psychosis.

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29. A client on the unit suddenly cries out in fear. The nurse notices that the client's head is twisted to one side, his back is arched, and his eyes have rolled back in their sockets. The client has recently begun drug therapy with haloperidol (Haldol). Based on this assessment, the first action of the nurse would be to
    A) get a stat. order for a serum drug level.
    B) hold the client's medication until the symptoms subside.
    C) place an urgent call to the client's physician.
    D) give a PRN dose of benztropine (Cogentin) IM.
    Ans: D
    Feedback:
    The client is having an acute dystonic reaction; the treatment is anticholinergic medication. Dystonia is most likely to occur in the first week of treatment, in clients younger than 40 years, in males, and in those receiving high-potency drugs such as Haldol. Immediate treatment with anticholinergic drugs usually brings rapid relief.

30. One week after beginning therapy with thiothixene (Navane), the client demonstrates muscle rigidity, a temperature of 103∞F, an elevated serum creatinine phosphokinase level, stupor, and incontinence. The nurse should notify the physician because these symptoms are indicative of
    A) acute dystonic reaction.
    B) extrapyramidal side effects.
    C) neuroleptic malignant syndrome.
    D) tardive dyskinesia.
    Ans: C
    Feedback:
    The client demonstrates all the classic signs of neuroleptic malignant syndrome. Dystonia involves acute muscular rigidity and cramping, a stiff or thick tongue with difficulty swallowing, and, in severe cases, laryngospasm and respiratory difficulties. Extrapyramidal side effects are reversible movement disorders induced by antipsychotic or neuroleptic medication. Tardive dyskinesia is a late-onset, irreversible neurologic side effect of antipsychotic medications characterized by abnormal, involuntary movements, such as blinking, chewing, and grimacing.

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31. A client with bipolar disorder has been taking lithium, and today his serum blood level is 2.0 mEq/L. What effects would the nurse expect to see?
    A) Constipation and postural hypotension
    B) Fever, muscle rigidity, and disorientation
    C) Nausea, diarrhea, and confusion
    D) None; the serum level is in therapeutic range
    Ans: C
    Feedback:
    Serum lithium levels of less than 0.5 mEq/L are rarely therapeutic, and levels of more than 1.5 mEq/L are usually considered toxic. The client would show signs of toxicity with a lithium level of 2.0 mEq/L. Toxic effects of lithium are severe diarrhea, vomiting, drowsiness, muscle weakness, and lack of coordination.

32. For a client taking clozapine (Clozaril), which of the following symptoms should the nurse report to the physician immediately as it may be indicative of a potentially fatal side effect?
    A) Inability to stand still for 1 minute
    B) Mild rash
    C) Photosensitivity reaction
    D) Sore throat and malaise
    Ans: D
    Feedback:
    Clozapine (Clozaril) produces fewer traditional side effects than do most antipsychotic drugs, but it has the potentially fatal side effect of agranulocytosis. This develops suddenly and is characterized by fever, malaise, ulcerative sore throat, and leukopenia. This side effect may not be manifested immediately and can occur up to 24 weeks after the initiation of therapy. Any symptoms of infection must be investigated immediately. Agranulocytosis is characterized by fever, malaise, ulcerative sore throat, and leukopenia. Mild rash and photosensitivity reaction are not serious side effects.

33. A patient with bipolar disorder takes lithium 300 mg three times daily. The nurse evaluates that the dose is appropriate when the patient reports
    A) feeling sleepy and less energetic.
    B) weight gain of 7 pounds in the last 6 months.
    C) minimal mood swings.
    D) increased feelings of self-worth.
    Ans: C
    Feedback:
    Mood-stabilizing drugs are used to treat bipolar disorder by stabilizing the client's mood, preventing or minimizing the highs and lows that characterize bipolar illness, and treating acute episodes of mania. Weight gain is a common side effect, and fatigue and lethargy may indicate mild toxicity. Inflated self-worth is a target symptom of bipolar disorder, which should diminish with effective treatment.

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34. When the client experiences facial flushing, a throbbing headache, nausea and vomiting after consuming alcohol while taking Disulfiram (Antabuse), the nurse is aware that this is due to which of the following?
    A) A mild side effect of the medication.
    B) The intended therapeutic result.
    C) An idiosyncratic reaction
    D) A severe allergy to the medication.
    Ans: B
    Feedback:
    Disulfiram is a sensitizing agent that causes an adverse reaction when mixed with alcohol in the body. Five to ten minutes after a person taking disulfiram ingests alcohol, symptoms begin to appear: facial and body flushing from vasodilation, a throbbing headache, sweating, dry mouth, nausea, vomiting, dizziness, and weakness. These symptoms are not mild side effects because these are very uncomfortable symptoms. These symptoms would not be an idiosyncratic reaction because this is the expected reaction. These symptoms are not indicative of a severe allergy to the medication.

35. When the client asks the nurse how long it will take before the SSRI antidepressant medication will be effective, which of the following replies is most accurate and therapeutic?
    A) ìThis is a good medication! It will be effective within 20 minutes of the first dose.î
    B) ìYou will have gradual improvement in symptoms over the next few weeks, but the changes may be so subtle that you may not notice them for a while. It is important for you to keep taking the medication.î
    C) ìIt will probably take months for the medication to work. In the meantime, you should work on improving your attitude.î
    D) ìIf you believe it will work, then it will. You have to have faith!î
    Ans: B
    Feedback:
    SSRIs may be effective in 2 to 3 weeks. Researchers believe that the actions of these drugs are an ìinitiating eventî and that eventual therapeutic effectiveness results when neurons respond more slowly, making serotonin available at the synapses. The medication will not be effective within 20 minutes of the first dose, and it will not likely take months for the medication. Attitude and faith will improve with the medication's effectiveness.

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36. A client has a lithium level of 1.2 mEq/L. Which of the following interventions by the nurse is indicated?
    A) Call the physician for an increase in dosage.
    B) Do not give the next dose, and call the physician.
    C) Increase fluid intake for the next week.
    D) No intervention is necessary at this time.
    Ans: D
    Feedback:
    The lithium level is within the therapeutic range. Serum levels of less than 0.5 mEq/L are rarely therapeutic, and a level of more than 1.5 mEq/L is usually considered toxic. Answers A, B, and C are not appropriate interventions for the given lithium level.

37. A patient is seen for frequent exacerbation of schizophrenia due to nonadherence to medication regimen. The nurse should assess for which of the following common contributors to nonadherence?
    A) The patient is symptom-free and therefore does not need to adhere to the medication regimen.
    B) The patient cannot clearly see the instructions written on the prescription bottle.
    C) The patient dislikes the weight gain associated with antipsychotic therapy.
    D) The patient sells the antipsychotics to addicts in the neighborhood.
    Ans: C
    Feedback:
    Patients with schizophrenia are less likely to exercise or eat low-fat nutritionally balanced diets; this pattern decreases the likelihood that they can minimize potential weight gain or lose excess weight. Antipsychotics should be taken regularly and not omitted when free of symptoms. Antipsychotics do not adversely affect vision, nor do they have addictive potential.

38. Which of the following side effects of lithium are frequent causes of noncompliance? Select all that apply.
    A) Metallic taste in the mouth
    B) Weight gain
    C) Acne
    D) Thirst
    E) Lethargy
    Ans: B, E
    Feedback:
    Lethargy and weight gain are difficult to manage or minimize and frequently lead to noncompliance.

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39. The nurse is educating a patient and family about strategies to minimize the side effects of antipsychotic drugs. Which of the following should be included in the plan? Select all that apply.
    A) Drink plenty of fruit juice.
    B) Developing an exercise program is important.
    C) Increase foods high in fiber.
    D) Laxatives can be used as needed.
    E) Use sunscreen when outdoors.
    F) For missed doses, take double the dose at the next scheduled time.
    Ans: B, C, E
    Feedback:
    Drinking sugar-free fluids and eating sugar-free hard candy ease dry mouth. The client should avoid calorie-laden beverages and candy because they promote dental caries, contribute to weight gain, and do little to relieve dry mouth. Methods to prevent or relieve constipation include exercising and increasing water and bulk-forming foods in the diet. Stool softeners are permissible, but the client should avoid laxatives. The use of sunscreen is recommended because photosensitivity can cause the client to sunburn easily. If the client forgets a dose of antipsychotic medication, he or she can take the missed dose if it is only 3 or 4 hours late. If the dose is more than 4 hours overdue or the next dose is due, the client can omit the forgotten dose.

40. The nurse has completed health teaching about dietary restrictions for a client taking a monoamine oxidase inhibitor. The nurse will know that teaching has been effective by which of the following client statements?
    A) ìI'm glad I can eat pizza since it's my favorite food.î
    B) ìI must follow this diet or I will have severe vomiting.î
    C) ìIt will be difficult for me to avoid pepperoni.î
    D) ìNone of the foods that are restricted are part of a regular daily diet.î
    Ans: C
    Feedback:
    Pepperoni is one of the foods containing tyramine, so it must be avoided. Particular concern to this client is the potential life-threatening hypertensive crisis if the client ingests food that contains tyramine. Answer choices A, B, and D are inappropriate statements toward effective teaching for the client receiving a monoamine oxidase inhibitor.

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41. When teaching a client about restrictions for tranylcypromine (Parnate), the nurse will tell the client to avoid which of the following foods?
    A) Broad beans
    B) Citrus fruit
    C) Egg products
    D) Fried foods
    Ans: A
    Feedback:
    Parnate is a monoamine oxidase inhibitor; clients must avoid tyramine, and broad beans contain tyramine. Answers citrus fruit, egg products, and fried foods are not tyramine-containing foods.

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