

Keltner: Psychiatric Nursing, 6th Edition

Chapter 03: Models for Working with Psychiatric Patients

Test Bank

MULTIPLE CHOICE

1. When interacting with patients, it is important for the nurse to recognize that defense mechanisms:
 - a. keep id impulses from gaining control.
 - b. protect the ego from excessive anxiety.
 - c. access unconscious feelings and memories.
 - d. prevent conflict among the id, ego, and superego.

ANS: B

Theorists widely accept the Freudian concept that ego defense mechanisms operate unconsciously to lower anxiety. The function of defense mechanisms is limited to anxiety control, so the other options are incorrect.

DIF: Cognitive level: Comprehension REF: 21-23

TOP: Nursing process:

Planning

MSC: NCLEX: Psychosocial Integrity

2. A nurse supports a patient's ego. This intervention is therapeutic because the individual's ego:
 - a. provides rational, logical reality testing.
 - b. is primarily concerned with right and wrong.
 - c. uses primary process imagery to meet basic needs.
 - d. is derived from the individual's pattern of thinking.

ANS: A

The ego focuses on the reality principle and uses secondary process thinking, a logical, rational operation to maintain the well-being of the individual. The superego is concerned with right and wrong. The id uses primary process. Ego formation is influenced by heredity, environment, and maturation.

DIF: Cognitive level: Comprehension REF: 20

TOP: Nursing process: Implementation MSC: NCLEX: Psychosocial Integrity

3. A patient asks, "Why it is important to uncover memories and conflicts hidden in the unconscious?" A Freudian therapist would explain that bringing unconscious information to consciousness will:
 - a. resolve developmental issues, fears, and crises.
 - b. allow an individual control over the id and superego.
 - c. suppress painful feelings and increase rational thinking.

- d. provide insight into behavior and allow meaningful change to occur.

ANS: D

Freud believed that uncovering unconscious material generates an understanding of behavior that enables individuals to make choices about behavior and thus improve mental health. It will not, however, automatically resolve issues, give the patient control over id and superego strivings, or result in rational thinking.

DIF: Cognitive level: Application REF: 20

TOP: Nursing process: Implementation MSC: NCLEX: Psychosocial Integrity

4. A patient uses defense mechanisms excessively. The nurse should expect to find evidence that:
- a. the patient has difficulty with problem solving.
 - b. the patient has an increased risk for psychosis.
 - c. emotions are experienced with great intensity.
 - d. reality is denied.

ANS: A

Excessive use of defense mechanisms results in the distortion of reality. When reality is not perceived accurately, problem solving is impaired. The other options might or might not be experienced by the patient.

DIF: Cognitive level: Application REF: 22

TOP: Nursing process: Assessment MSC: NCLEX: Psychosocial Integrity

5. A patient has severe panic attacks and uses denial, repression, and displacement. Nursing interventions should be directed toward:
- a. teaching more effective coping strategies.
 - b. setting limits on use of the defense mechanisms.
 - c. assisting the patient to change values and beliefs.
 - d. helping the patient uncover unconscious conflicts.

ANS: A

A desired outcome would be that the patient will use more effective coping strategies. Nursing intervention would focus on helping the patient identify and use more adaptive coping strategies. Setting limits on the use of defense mechanisms is impossible. Values clarification might be unnecessary. Uncovering conflicts is not a focus of nursing intervention.

DIF: Cognitive level: Analysis REF: 22 | 23

TOP: Nursing process: Implementation MSC: NCLEX: Psychosocial Integrity

6. A 29-year-old lives with his parents, has few interpersonal relationships, and says, "Most people can't be trusted." This person makes decisions only after consulting with his parents. Using Erikson's developmental theory, the nurse can draw which conclusion?
- a. The patient has evidence of inferiority and lacks a sense of direction.
 - b. Developmental deficits in early life have impaired the patient's adult functioning.
 - c. The patient's developmental problems will probably lead to a serious mental illness.
 - d. It is impossible for the patient to proceed to the next developmental stage until mastering earlier stages.

ANS: B

The patient achieved only partial mastery of the trust versus mistrust stage. Deficits in development carried from one stage to the next interfere with functioning at the adult level. Individuals do progress from stage to stage when mastery is not attained, however adjustment is usually impaired. Developmental problems might lead to a serious mental disorder, but might also produce less serious results.

DIF: Cognitive level: Application
Analysis

REF: 23-26

TOP: Nursing process:

MSC: NCLEX: Health Promotion and Maintenance

7. When the nurse conducts a developmental assessment with a new patient, the assessment can be expected to yield information:
- a. regarding use of defense mechanisms.
 - b. about the degree of mastery of critical tasks.
 - c. that will help the patient make rational decisions.
 - d. about mobilization of defenses against stressors.

ANS: B

According to Erikson's developmental theory, a developmental assessment is conducted for the purpose of determining the extent to which an individual has successfully mastered the critical task of each stage of development up to his or her chronologic age. Lack of mastery or partial mastery will yield clues about issues to be addressed in working with the patient. Because of its focus, the developmental assessment might yield only minimal information about defense mechanism use and defenses used to cope with stress. Rational decision making is not expected to be fostered as a result of developmental assessment.

DIF: Cognitive level: Application
TOP: Nursing process: Assessment
Maintenance

REF: 23-24

MSC: NCLEX: Health Promotion and

8. A patient has lung cancer, continues to smoke, and says, “I think my cancer is more the result of a bad gene than of smoking.” The patient shows the use of which defense mechanism?
- a. Denial
 - b. Compensation
 - c. Intellectualization
 - d. Reaction formation

ANS: A

Denial is the unconscious refusal to admit an unacceptable idea or behavior, as shown in this example. Compensation refers to covering a weakness by overemphasizing a desirable trait. Intellectualization involves using a logical explanation without expressing emotion or affect. Reaction formation is a conscious behavior that is the opposite of an unconscious feeling.

DIF: Cognitive level: Application

REF: 22

TOP: Nursing process: Assessment

MSC: NCLEX: Psychosocial Integrity

9. A patient tells the nurse, “The reason I use drugs is because everybody nags me to do things that don’t interest me.” The patient shows use of which defense mechanism?
- a. Sublimation
 - b. Introjection
 - c. Identification
 - d. Rationalization

ANS: D

Rationalization is an attempt to prove that one’s behaviors or feelings are justifiable and involves making justifications of feelings or behaviors. Sublimation channels instinctual drives into acceptable channels. The patient is not modeling after another person or incorporating another’s values.

DIF: Cognitive level: Application

REF: 22

TOP: Nursing process: Assessment

MSC: NCLEX: Psychosocial Integrity

10. A patient is mute, curled in a fetal position, and incontinent of urine. The patient eats small amounts only if spoon-fed. The nurse assesses this behavior as most indicative of:
- a. displacement.
 - b. compensation.
 - c. conversion.
 - d. regression.

ANS: D

Regression is defined as the return to an earlier, more comfortable developmental state—in this case, infancy. Displacement involves discharging feelings to a less threatening object. Compensation refers to covering a weakness by overemphasizing a desirable trait.

Conversion refers to the unconscious expression of conflict symbolically through physical symptoms.

DIF: Cognitive level: Application

REF: 22

TOP: Nursing process: Assessment

MSC: NCLEX: Psychosocial Integrity

11. A 26-year-old woman has a realistic sense of self, a commitment to reasonable career goals, a satisfying intimate partner relationship, and a circle of loyal friends. This person says, "I volunteer for important projects in my community." The nurse can draw which conclusion?

- a. There is lack of mastery of critical tasks associated with the stage of industry versus inferiority.
- b. Mastery of critical tasks associated with the stage of identity versus role diffusion is evident.
- c. Fear of criticism and affection affect mastery of critical tasks associated with intimacy.
- d. The person vacillates between dependence and independence.

ANS: B

Adult behavior reflecting mastery of the critical tasks associated with the stage of identity versus role diffusion includes confident sense of self, emotional stability, commitment to career planning, sense of having a place in society, establishing a relationship with the opposite sex, fidelity to friends, and development of personal values. The behaviors given in the scenario are not indicators of any of the other options.

DIF: Cognitive level: Analysis

REF: 23-26

TOP: Nursing process:

Analysis

MSC: NCLEX: Health Promotion and Maintenance

12. A 25-year-old man complains of overwhelming guilt about minor social errors, feels self-pity, and says, "I stay on the sidelines of life so I can avoid the embarrassment of being noticed." The nurse can assess deficits in mastery of critical tasks associated with which developmental stage?

- a. Trust versus mistrust
- b. Industry versus inferiority
- c. Autonomy versus shame and doubt
- d. Generativity versus self-absorption

ANS: B

Adult behaviors reflecting developmental problems associated with the stage of industry versus inferiority include excessive guilt and embarrassment, passivity, apathy, rumination and self-pity, assumption of the victim role, and underachievement of potential. The behaviors given in the scenario reflect the critical tasks of industry versus inferiority. Tasks of the other stages are entirely different.

DIF: Cognitive level: Analysis

REF: 23-26

TOP: Nursing process:

Analysis

MSC: NCLEX: Health Promotion and Maintenance

13. A 75-year-old retired executive complains, "I am unable to say 'no' when asked to help with community causes. These projects overtax my strength, but if I don't do them, who will?" The nurse can assess that this person is having difficulty with critical tasks related to which developmental stage?
- Trust versus mistrust
 - Integrity versus despair
 - Identity versus role diffusion
 - Autonomy versus shame and doubt

ANS: B

Adult behaviors reflecting problems associated with the developmental stage of integrity versus despair include inability to reduce activities, overtaxing strength, and feeling indispensable, or the opposite: feeling helpless, useless, or lonely; focusing on past mistakes; and inability to occupy oneself with satisfying activities. Tasks of the other stages are not described in the scenario.

DIF: Cognitive level: Analysis

REF: 22-26

TOP: Nursing process:

Analysis

MSC: NCLEX: Health Promotion and Maintenance

14. The nurse who uses the interpersonal model as a basis for practice will focus assessment on identifying:
- intrapsychic conflicts.
 - relationship problems.
 - how the environment affects behavior.
 - the patient's achievement of development tasks.

ANS: B

Interpersonal therapists assess for current difficulties in the patient's relationships with others. Learning new, more effective interpersonal skills becomes a goal of therapy. Psychoanalytic therapists focus on intrapsychic conflicts. The other options are not the focus of the model.

DIF: Cognitive level: Comprehension

REF: 24 | 26

TOP: Nursing process:

Planning

MSC: NCLEX: Health Promotion and Maintenance

15. Select the goal most likely to be chosen for a patient by a nurse who uses the interpersonal model as a basis for practice. The patient will:
- develop mature, satisfying relationships that are relatively free of anxiety.
 - rid self of irrational beliefs, including "shoulds," "oughts," and "musts."
 - learn to meet basic needs responsibly.
 - manage stress adaptively.

ANS: A

The goal of interpersonal therapists is to assist the patient in developing healthy interpersonal relationships that are relatively anxiety-free. The other distracters state a goal appropriate for cognitive therapy, reality therapy, and stress management therapy, respectively.

DIF: Cognitive level: Application REF: 24 | 26 TOP: Nursing process: Planning

MSC: NCLEX: Psychosocial Integrity

16. A 26-month-old child displays negative behaviors. The parent says, "My child refuses toilet training and shouts 'No!' when given direction. What do you think is wrong?" Select the nurse's best reply.

- a. "This is normal for your child's age. The child is striving for independence."
- b. "The child needs firmer control. Punish the child for defiance and saying 'no.'"
- c. "There may be developmental problems. Most children are toilet trained by age 2."
- d. "Some undesirable attitudes are developing. A child psychologist can help you develop a remedial plan."

ANS: A

The distracters indicate that the child's behavior is abnormal when, in fact, this behavior is typical of a child around the age of 2 years whose developmental task is to develop autonomy.

DIF: Cognitive level: Application REF: 25
TOP: Nursing process: Implementation MSC: NCLEX: Health Promotion and Maintenance

17. A nurse clinician uses rational-emotive therapy with a patient who is chronically depressed. The initial step in this process is to help the patient:

- a. identify developmental tasks and progress.
- b. manage environmental stressors more effectively.
- c. explore childhood influences on the patient's emotional state.
- d. recognize how irrational beliefs are related to painful feelings.

ANS: D

Cognitive therapists believe that irrational beliefs or automatic thoughts cause self-defeating behaviors to be maintained. Individuals can challenge their self-defeating behaviors once they identify irrational beliefs and see their connection to painful feelings. The other options reflect interventions that might occur later.

DIF: Cognitive level: Analysis REF: 27-28
TOP: Nursing process: Implementation MSC: NCLEX: Psychosocial Integrity

18. A patient says, "It's my fault because I always make bad decisions. I should never have taken that job." Using a rational-emotive approach, how would the nurse respond?
- "What can you do to solve your problems at work?"
 - "You're experiencing a great deal of stress right now. How can you manage it more effectively?"
 - "Can you describe a time in your childhood when your parents blamed you for things you didn't do?"
 - "Consider the words you are using to talk about yourself. Let's try to change those words to more positive ones."

ANS: D

The therapist using rational-emotive therapy helps the patient identify irrational thoughts and replace them with new, more positive self-statements to enable the patient to think, feel, and behave differently. The other options do not make use of the combination of cognitive, emotive, and behavioral components.

DIF: Cognitive level: Analysis REF: 27-28
TOP: Nursing process: Implementation MSC: NCLEX: Psychosocial Integrity

19. During an interdisciplinary team meeting, a nurse says, "The patient's psychological distress seems to result from automatic thoughts that cause self-defeating behaviors." The nurse is conceptualizing the patient's problem from the viewpoint of which model?
- Interpersonal
 - Psychoanalytic
 - Stress-adaptation
 - Cognitive-behavioral

ANS: D

The cognitive-behavioral model recognizes the role of automatic thoughts (irrational beliefs) in promulgating self-defeating behaviors. The information given in the scenario does not reflect conceptualization using any of the other models.

DIF: Cognitive level: Application REF: 27-28 TOP: Nursing process:
Analysis
MSC: NCLEX: Psychosocial Integrity

20. The parent of a 4-year-old child rewards and praises the child for helping a sibling, being polite, and using good manners. The nurse supports the use of praise because these qualities will likely be internalized and become part of the child's:
- id.
 - ego.
 - superego.
 - preconscious.

ANS: C

The superego contains the “thou shalts,” or moral standards internalized from interactions with significant others. Praise fosters internalization of desirable behaviors. The id is the center of basic instinctual drives, and the ego is the mediator. The ego is the problem-solving and reality-testing portion of the personality that negotiates solutions with the outside world. The preconscious is a level of awareness from which material can be retrieved easily with conscious effort.

DIF: Cognitive level: Comprehension REF: 20

TOP: Nursing process: Assessment MSC: NCLEX: Psychosocial Integrity

21. Which statement by an adult would lead a nurse to suspect deficits in mastery of the developmental task of infancy?

- a. “I have many warm and close friendships.”
- b. “I am afraid to let anyone really get to know me.”
- c. “I am always right. Keep your opinion to yourself.”
- d. “I am ashamed I did that wrong. Please forgive me.”

ANS: B

According to Erikson, the developmental task of infancy is the development of trust. The key is the only statement clearly showing the lack of ability to trust others. The distracters suggest that the developmental task of infancy was successfully completed: rigidity rather than mistrust, and failure to resolve the crisis of initiative versus guilt.

DIF: Cognitive level: Analysis

REF: 25

TOP: Nursing process:

Analysis

MSC: NCLEX: Health Promotion and Maintenance

22. A student nurse says, “I don’t need to interact with my patients. I learn by observing them.” The instructor can best interpret the nursing implications of Sullivan’s theory to this student by responding:

- a. “Nurses cannot be isolated. We must interact to provide patients with opportunities to practice interpersonal skills.”
- b. “Observing patient interactions can help you formulate priority nursing diagnoses and appropriate interventions.”
- c. “I wonder how accurate your assessment of the patient’s needs can be if you do not interact with the patient.”
- d. “It is important to note patient behavioral changes because these signify changes in personality.”

ANS: A

Sullivan believed that the nurse’s role includes educating patients and assisting them in developing effective interpersonal relationships. Mutuality, respect for the patient, unconditional acceptance, and empathy are cornerstones of Sullivan’s theory. These cornerstones cannot be demonstrated by the nurse who does not interact with the patient. Observations provide only objective data. Priority nursing diagnoses usually cannot be

accurately established without subjective data from the patient. The other distracters relate to Maslow's theory and behavioral theory.

DIF: Cognitive level: Application REF: 26

TOP: Nursing process: Implementation MSC: NCLEX: Psychosocial Integrity

23. The nurse using the Lazarus Interactional Model should make it an early priority to assess the individual's response to stress and:

- a. physical condition.
- b. appraisal of the threat.
- c. ability to use relaxation techniques.
- d. childhood experiences in dealing with stress.

ANS: B

According to Lazarus, the significance of the threat or what it means to the individual is of primary importance in determining the individual's response. This personal evaluation is based on cognitive appraisal. The other options are of lesser importance initially.

DIF: Cognitive level: Comprehension REF: 29-30

TOP: Nursing process: Assessment MSC: NCLEX: Psychosocial Integrity

24. A recently divorced parent attending a stress management class says, "I need to keep myself together, but I'm having difficulty thinking straight." The parent reports frequent headaches, neck tension, and a moderate level of anxiety. This patient is probably in which stage of the general adaptation syndrome?

- a. Panic.
- b. Alarm.
- c. Resistance.
- d. Exhaustion.

ANS: C

The scenario is most consistent with the stage of resistance. In the stage of resistance, individuals strive to adapt to stress. Problem solving is difficult, but not impossible with assistance. Psychosomatic symptoms often appear. Anxiety is usually assessed as moderate to severe. Panic is reflected by complete disorganization and is not considered a stage of the stress-adaptation model. Alarm is characterized by flight-or-fight behaviors. Exhaustion is characterized by severe to panic level anxiety.

DIF: Cognitive level: Analysis REF: 28-29

TOP: Nursing process: Assessment MSC: NCLEX: Psychosocial Integrity

25. A patient says, "This problem with my job is overwhelming. I don't know what to do." The nurse replies, "Let's role-play some work situations and try to come up with solutions." Using Lazarus's interaction model, the nurse is intervening in:

- a. primary appraisal.
- b. secondary appraisal.

- c. tertiary appraisal.
- d. reappraisal.

ANS: B

Secondary appraisal is defined as the individual's evaluation of how to respond to an event. During secondary appraisal, the individual can examine possible strategies, solutions, resources, and supports. Primary appraisal refers to judgments the person makes about the event. Reappraisal occurs after new information has been received. Tertiary appraisal is not part of the model.

DIF: Cognitive level: Analysis REF: 29-30

TOP: Nursing process: Implementation MSC: NCLEX: Psychosocial Integrity

26. A patient has delusions of persecution and hears voices saying, "You are worthless." The nurse who uses Selye's stress-adaptation model would assess these symptoms as arising from which stage?
- a. Alarm
 - b. Resistance
 - c. Exhaustion
 - d. Reappraisal

ANS: C

The scenario describes behaviors seen in the stage of exhaustion. The stage of exhaustion is characterized by exaggerated and dysfunctional defenses, personality disorganization, illogical thinking, delusions and hallucinations, and reduced orientation to reality. Alarm behaviors are demonstrated by flight-or-fight reactions. Resistance behaviors include increased use of coping and defense mechanisms. Reappraisal is not a stage of the stress-adaptation model.

DIF: Cognitive level: Analysis

REF: 29

TOP: Nursing process:

Analysis

MSC: NCLEX: Psychosocial Integrity

27. An individual with alcohol dependence will begin motivational enhancement therapy. The nurse will explain this therapy to significant others as a way of:
- a. altering the patient's irrational thoughts.
 - b. enhancing the patient's willingness to change behavior.
 - c. managing anxiety through satisfying interpersonal interactions.
 - d. mastering critical developmental tasks not attained earlier in life.

ANS: B

This variation of cognitive-behavioral therapy uses motivational interviewing to bolster the patient's readiness and willingness to change habits related to the addiction. Motivational enhancement therapy is a nonconfrontational approach that uses empathy and promotes self-efficacy. The other options are consistent with interpersonal therapy, cognitive therapy, and the use of Erikson's model.

DIF: Cognitive level: Comprehension REF: 28

TOP: Nursing process: Implementation MSC: NCLEX: Psychosocial Integrity

28. After an episode of self-mutilation, a patient with borderline personality disorder will begin individual therapy and group skills training. The goals are to decrease use of dissociation, increase distress tolerance, and regulate affect. Which type of therapy is evident?

- a. Rational-emotive behavioral
- b. Motivational enhancement
- c. Dialectical behavioral
- d. Interpersonal

ANS: C

Each of the components described in the scenario is a component of dialectical behavioral therapy. The scenario information is not consistent with the components of any of the other types of therapy given as options.

DIF: Cognitive level: Comprehension REF: 28

TOP: Nursing process: Implementation MSC: NCLEX: Psychosocial Integrity

MULTIPLE RESPONSE

1. A student goes to a party the night before a test and then fails the exam. After seeing the score, the student slams a book on the table and says, "I have to work so much and have no time to study. It wouldn't matter anyway because the teacher is unreasonable." The nurse identifies use of which defense mechanisms? Select all that apply.

- a. Denial
- b. Compensation
- c. Rationalization
- d. Projection
- e. Displacement
- f. Reaction formation

ANS: C, D, E

The student slams down the book, displacing anger, rationalizes (makes excuses), and projects blame onto the teacher. Compensation involves making up for a perceived weakness by emphasizing a desirable trait. Projection refers to blaming others or attributing unacceptable thoughts to behaviors to others. Reaction formation involves doing the opposite of an unacceptable desire.

DIF: Cognitive level: Analysis REF: 22

TOP: Nursing process: Assessment MSC: NCLEX: Psychosocial Integrity

2. After being informed of a diagnosis of lung cancer, a patient says in a cheerful voice, "I feel fine. I will do some reading online about it. Right now, I want to take a nap." The nurse assesses the use of which defense mechanisms? Select all that apply.
- a. Repression
 - b. Undoing
 - c. Introjection
 - d. Reaction formation
 - e. Intellectualization
 - f. Suppression

ANS: D, E, F

The cheerful voice is probably the result of reaction formation. The wish to read more about the diagnosis reflects intellectualization. Taking a nap is suppression and allows the patient to avoid having to think about the problem. Repression results in unconscious forgetting. Undoing involves doing something to make up for an unacceptable act. Introjection is incorporating values and attitudes of others as if they were one's own.

DIF: Cognitive level: Analysis

REF: 22

TOP: Nursing process: Assessment

MSC: NCLEX: Psychosocial Integrity