NURSING PRACTICE V-ANSWERS AND RATIONALES

1. **Answer. D**
Option D is seeking clarification after the nurse was unable to understand the client. Option A is exploring, option b is placing event in time or sequence, and option C is focusing.

2. **Answer: B**
The hypothalamus is located in the deincephalon and Is responsible for regulating temperature, appetite, and the integration of the autonomic nervous system. The thalamus (option A) is also located in the diencephalons, and is functions are concerned primarily with sensation. The cerebrum's (option C) primary functions include higher-order thinking, abstract reasoning, visual functions, judgment, memory, and sensory function. The cerebellum (option D) is primarily responsible for balance and coordination.

3. **Answer: C**
A situational crisis is one that is often sudden and unavoidable. The stressful event threatens a person's physical, emotional, or social integrity. An adventitious crisis (option A) occurs from an accidental or sporadic event. A maturational crisis (option B) occurs because of the situation occurring from the maturing process, such as in the adolescents or older adults. A social crisis (option D) is a crisis that occurs within a social context.

4. **Answer: A**
It is helpful for the client to identify the feelings he or she has about the crisis in order to feel validated and begin work on the problem. The realistic nature of the event (option B), others impacted by the events (option C), and a plan of action (option D) all are important next steps once the client has identified hi or her own feelings.

5. **Answer: B**
The nurse must remain focused on the immediate problem as there is not enough time and no need to delve into the complete past history (option A). The client's role in the current crisis (option C) is not relevant at this time, although it may be more important in learning to prevent future crisis situations. Assisting the client to identify that is similar about this crisis to other crisis (option D) may be a usual next step.

6. **Answer: A**
While some clients will not talk about thoughts of self- harm, they will usually talk about suicidal thoughts when asked. Safety is priority and suicidal clients should not be left alone. Altered thought process (option B) , psychiatric providers (option C) and feeling toward dying (option D) are important assessment areas after the client's safety has been ensured.

7. **Answer: C**
One desired outcome is for the client to have enhanced social support. The client should be sleeping better by discharge (option 1). Taking care of her plants (option B) and cooking for herself (option D) do not necessarily indicate the client's level of recovery.

8. **Answer: C**
Central nervous system stimulants such as Ritalin are the most frequently used medications for ADHD. These medications increase the ability to focus attention by blocking out irrelevant thoughts and impulses. Antidepressants (options A and B) may be used, but venlafaxine (Effexor) and fluvoxamine (Luvox) seem to be the most effective. Cyclert (option D) is used for ADHD, may have fewer side effects, but is used less often because it takes up to 8 weeks to take effect.

9. **Answer: D**
DSM-IV-TR states that depressed mood or loss of interest in previously enjoyed activities must be present in order to qualify for a diagnosis of major depression. Although each of the other options may be present with depression, these criteria must be met first.

10.**Answer. D**
Any client who is being evaluated for a mood disorder should have a workup to rule out the possibility of a pathophysiologic disorder being overlooked. The body systems listed in options A, B, and C would not have actual irregularities that would indicate the same signs and symptoms as mood disorders.

11.**Answer: C**
Frequent and repetitive worries and behaviors are signs of an obsessive-compulsive disorder. Acute stress disorder and generalized anxiety disorders are characterized by a great deal of difficulty controlling unrealistic, excessive anxiety associated with common daily experiences or activities. Panic disorders are characterized by recurrent panic attacks and the source of the anxiety may not be identified.

12.**Answer: C**
Family members must understand the mechanism of somatization disorder, and to have their own needs addressed. The chronic nature of the physical complaints is very frustrating and disrupting of family functioning.

13.**Answer: A**
Somatoform disorders result in altered role performance because the illness interferes with the usual responsibilities in life. There is not enough data to support knowledge deficit or risk for self-directed violence. Acute trauma reaction does not exist.

14.**Answer: B**
The client's statement indicates accurate awareness of mind-body interaction. She does not suggest the symptoms are something to medicate, nor does she persist in identifying her illness as physical in origin, both of which are characteristic of somatization disorder.

15. **Answer: B**
The nurse must accept the client's statement and beliefs as real to the client to develop trust and move into a therapeutic relationship.
A – Clients can't be argued out of delusions
C – These feelings and thoughts are constant; this would result in an overdose.
D – Redirecting the client's conversation whenever negative topics are brought up adds to the client's feelings that negative thoughts are correct.

16.**Answer: D**
The nurse should provide physical care for the client in a matter-of-fact manner and, at the same time, should help the client note how symptoms increase at the time of stress and can be a way of coping with stress.

17.**Answer: D**
Participating in group therapy offers a chance to talk and to gain support from others, both of which free up energy.

18.**Answer: B**
A localized amnesia is characterized by the inability to recall all events associated with a stressful event; whereas continuous amnesia would include the present (and the client is oriented to person, place, or time). Denial is an unconscious defense mechanism in which emotional conflict and anxiety are avoided by refusing to acknowledge those thoughts, feelings, or desires. Confabulation is the replacement of gaps in memory with imaginary information.

19.**Answer: C**
The described behavior reflects DSM-IV diagnostic criteria for antisocial personality disorder. His behavior is not characteristic of individuals diagnosed with narcissistic, histrionic, or border-line personality disorder.

20.**Answer: C**
The described behavior reflects DSM-IV diagnostic criteria for avoidant personality disorder. His behavior is not characteristic of individuals diagnosed with schizotypal, paranoid or schizoid personality disorder.

21.**Answer: C**
Individuals diagnosed with antisocial personality disorder display decreased impulse control, can be irritable and aggressive, and lack remorse or their action. Recognizing the potential risk for violence and maintaining client safety is the first priority of nursing care. The other nursing diagnoses do not reflect the behavioral pattern associated with individuals diagnosed with antisocial personality disorder.

22.**Answer: D**
Individuals diagnosed with borderline personality disorder frequently display a tendency to dichotomous thinking or splitting. They perceive the self and others as all good or all bad. The acting out, and passive aggressive behavior do not involve a tendency to perceive the self and others as all good or bad.

23.**Answer: C**
Plans, Promises, and words do not reflect actual behavioral change. Change is reflected in action.

24.**Answer: C**
Clang associations are association disturbances in which schizophrenic clients rhyme words in a sentence that make no sense. Echopraxia is meaningless imitation of motions made by others (option A). Echolalia is involuntary parrot-like repetition of words spoken by others (option B). Neologism is the coining of a new word that is meaningless to anyone but the client (option D).

25.**Answer: B**
Atypical antipsychotic medications are helpful in treating both negative (option D) and positive (option C) symptoms of schizophrenia. This class of medications has minimal to no risk for extrapyramidal side effects, which includes tardive dyskinesia (option A).

26.**Answer: A**
Akathisia is an extrapyramidal side effect of antipsychotic medications that may manifest as subjective and objective restlessness. Akinesia (option B), dystonia (option C), and tardive dyskinesia (option D) are also extrapyramidal side effects of antipsychotic medications, but are not characteristic of this client's symptoms.

27.**Answer: A**
Schizophrenia, disorganized type, is characterized by disorganized speech patterns. Other manifestations of this diagnosis include disorganized behavior and inappropriate affect. Sleep pattern disturbance (option B), Social isolation (option C), and Self-care deficit (option D) are possible, but not classic for disorganized schizophrenia.

28.**Answer: D**
Loose associations are considered to be a positive symptom associated with schizophrenia because they indicate a distortion or excess of normal functioning. Alogia (option A), avolition (option B), and social withdrawal (option C) are considered negative symptoms of schizophrenia. Negative symptoms indicate a loss or lack of normal functioning. Negative symptoms develop over time and hinder the client's ability to endure life tasks.

29.**Answer: C**
During stage 2 of Alzheimer's disease, clients have a need to place objects in the mouth so they can taste or chew them, causing a health hazard. This behavior is called hyperorality. Hyperactivity is behavior characterized by decreased attention span, increased impulsivity, and emotional lability. Hyperamorphosis is the need to compulsively touch and examine every object in the environment. Hyperemesis is characterized by excessive vomiting.

30.**Answer: D**
Donepezil (Aricept) is a cholinesterase inhibitor that appears to slow down cognitive deterioration in individual with mild to moderate dementia. All other options may be prescribed for clients with dementia but have no proven effect for regaining cognitive function.

31.**Answer: A**
The highest priority is given to nursing interventions that will maintain life; therefore basic physiological needs must be addressed initially with the baseline vital signs. Nutrition and fluid balance may be maintained by IV therapy once vital signs are evaluated and a physician's order is obtained. Checking the levels of orientation is important but does not provide any new information to the nurse. Sedative medications may complicate an attempt to identify the original cause of the confusion.

32.**Answer: D**
Clients with dementia often experience extreme agitation at the end of the day, probably as a result of tiredness and fewer orienting stimuli such as planned activities and contact with people. These restless and agitated behaviors worsen at night and are commonly referred to as Sundown syndrome. Pseudodementia is a reversible disorder that mimics dementia. Pseudodelirium is characterized by symptoms of delirium without any identifiable organic cause. Catastrophic reaction is the overreaction toward minor stresses that occurs in demented clients.

33.**Answer: D**
Psychoanalytic theory is based on Freud's belief regarding the importance of unconscious motivation for behavior and the role of the id and superego in opposition to each other. Behavioral, educational, and interpersonal theories do not emphasize unconscious conflicts as the basis for symptomatic behavior.

34.**Answer: A**
It would not be unusual for a client who has severe addiction to come to day treatment intoxicated and deny it. Denial would cause a client to insist he or she is not intoxicated or doesn't have a problem with alcoholism despite concrete evidence of the problem. Reaction formation is a defense mechanism that causes people to act exactly opposite to the way they feel (option B). Transference is the unconscious process of displacing feelings for significant people in the past unto the nurse in the recent relationship (option C). Countertransference is the nurse's emotional reaction to client base on feelings of significant people in the nurse's past (option D).

35.**Answer: C**
Alcohol use during pregnancy causes dysmorphic prenatal and postnatal difficulties and CNS dysfunction. Other substances cause significant health concerns as well, but not quite as many different kinds of problems (option, B and D).

36.**Answer: C**
Laxative abuse is a method used to control weight by anorexic and bulimics. Eating disorder clients may have cardiac rhythm disturbances but not necessarily chest pain (option D), headaches (option A), or altered sleep (option B) as a result of their disordered eating.

37.**Answer: C**
Clients who are unable to control their use or are unable to learn strategies to reduce intake and/ or harm caused by their use, are not a good candidates for this approach. People with tolerance (option A), alcohol abuse (option B), and high dose use (option D) may be successful in decreasing the frequency and quantity of alcohol they drink.

38.**Answer: B**
The quality of an adolescent's recovery environment can be helpful or hurtful to someone attempting to maintain sobriety. Friends or acquaintances may encourage a recovering person to use. The recovering adolescent may want to refuse but may not know how. Behavioral rehearsal, saying "no thanks" to an offer to engage in addictive behavior, can increase a recovering person's confidence. Vocational skills will not help the adolescent refuse a drink (option A). Problem-solving skills (option C) and communication skills (option D) may be useful but not as helpful as skills directly related to refusing to drink.

39.**Answer: A**
The numerous bruises and the mother's vague explanations of the injuries indicate possible child abuse. Home safety is important but not as important as the child's safety (option B). Falling down stairs frequently is not normal behavior for a 2-year-old (option C), nor is it a symptom of attention deficit disorder (option D)

40.**Answer: C**
Education and money do not make persons immune from violence. It crosses all socioeconomic lines. Violence does often begin in dating relationship (option A); abusers do apologize and promise to stop (option B); abusers are often excessively jealous and possessive (option D).

41.**Answer: D**
The client has been raped and nurse needs to respond to the client's immediate concerns. Testing (option A) and teaching (option B and C) are secondary interventions.

42.**Answer: C**
Inappropriate self-blame and feelings that a child could have stopped an adult's abuse indicate a low self-esteem. Option A, B, and D are possible diagnoses for adult survivors of abuse; there is not enough evidence supporting these diagnoses. More data would be needed.

43.**Answer: C**
Munchausen's Syndrome by Proxy is characterized by the caregiver reporting or producing symptoms in a child that require hospitalization and invasive procedures. The reports by the mother to have the child hospitalized point to Munchausen's. The physical appearance of the child and previous negative physical findings would rule out anxiety disorder (option A), bulimia (option B), and food allergies (option D).

44.**Answer: A**
The capacity of self-awareness allows the nurse to reflect and make choices. Nurses who understand their own feelings and beliefs will be able to be therapeutic when clients need to address issues which are disturbing and difficult. The death of the child will personally affect the nurse, and it is critical for the nurse to share these feelings with others, including the parents. The nurse must be available both physically and emotionally for the parents in discussing unpleasant and difficult feelings.

45.**Answer: C**
Spiritual beliefs and practices greatly influence both a person's and family's reaction to death and subsequent behavior. Although option A and B are correct, option C is more correct because their spiritual and cultural beliefs dictate these behaviors. The family may or may not trust the healthcare system.

46.**Answer: C**
A major outcome of grief counseling is to assist the client in sharing his or her loss and to accept support from others. It is critical for the spouse to share the feelings of loss and grief with others. It is too early to memorialize the spouse; the client must grieve the loss of client first.

47.**Answer: C**
Culture dictates acceptable customs and rituals used in the expression of grief, as well as, delineate the appropriate expression of feelings and behaviors.

48.**Answer: A**
Advance directives is a general term that refers to a client's written instructions about future medical care, in the event that the client becomes unable to speak or is incapacitated. Specific instructions about what medical treatment the client chooses to omit or refuse (e.g. Ventilator support) in the event that the client is unable to make those decisions is also included. The other options are not part of an advance directive.

49.**Answer: A**
Option A, anger, is included in the stages of grief as clients grieve for what has been lost. Although clients may experience multiple emotional feelings in response to diagnosis of life – changing medical illness, anger is one of the most common emotional responses because of the sudden and often dramatic change in lifestyle. Option B and C might occur but are not considered primary responses. Option D is inappropriate and typically does not occur.

50.**Answer: C**
The client's engagement with social supports woul hopefully results in increased ability to express emotions with others. Option A does not necessarily indicate a strong level of social support.

51.**Answer: B**
The nurse should help the client identify her coping strategies and her experience with past losses in order to identify the client's strengths and past coping strategies. This helps the client draw on experiences of the past to help her cope and look at events rationally. Focusing on the client's husband's current illness (option A) will only keep the client struck in hopelessness and helplessness. Focusing on loneliness and desolation (option C) and the future loss of her husband (option D) may be appropriate, but the nurse and client need to first examine how the client has coped with the past losses.

52.**Answer: A**
The purpose of defense mechanism is to reduce anxiety levels and allow the client to function adequately. Seeking isolation to avoid stress (option B) is an unhealthy adaptive strategy. Anxiety is expressed in behavior (option C); however, that behavior can be harmful to clients or others. Recognition of a stressor (option D) is important but may not be used in the client's adaptive use of defense mechanism.

53.**Answer: C**
Stereotyping arises out of negative biases; stereotypes are images frozen in time that cause us to see what we expect to see, even when the facts differ from our expectations. Countertrans-ference is the nurse's emotional reaction to a client based on feelings for significant people in the nurse's past. These would only reinforce the nurse's prejudices about the culture and cause the nurse to be insensitive, not sensitive, to the client's need (option A). When governed by stereotyping or countertransference, the nurse is unable to be open and honest (option B) and unable to facilitate effective treatment (option D).

54.**Answer: B**
The first priority of nurses in assisting clients to manage any area of their lives is to understand themselves and clarify their own spiritual beliefs and values. Referring clients to appropriate clergy (option A) may be an effective intervention, but the nurse has adequate skills in meeting many spiritual needs of the clients. Use of a spiritual assessment tool (option C) is important but should be used after the nurse has done self-exploration. Discussing the nurse's own religious beliefs (option D) is inappropriate and projects the nurse's own religious beliefs onto the client.

55.**Answer: B**
An older adult who expresses thoughts of death has priority over other choices- safety is always a priority. Everyone experiences grief differently. Older adults often normally experience grief somatically (option A). Guilt about actions or lack of action at the time of a loved one's death (option C) is not uncommon. A morbid preoccupation with worthlessness (option D) is a concern, but safety takes priority.

56.**Answer: A**
Behavior modification is quite effective with children and adolescents. The child is told what is expected, what is not acceptable, and consequences for undesirable behaviors. Open communication is effective, but a flexible approach may be confusing to the child (option B). Open expression of feelings (option C) and assertiveness training (option D) are useful techniques; however, they are more effective within a contrived environment.

57.**Answer: C**
Separation anxiety may develop at age, although it is most common in children, with the peak onset between 7 and 9 years old. Obsessive-compulsive disorder (option A), simple anxiety (option B), and PTSD (option D) are less common in children.

58.**Answer: C**
Behavior modification is quite effective with children and adolescents. The child is told what is expected, what is not acceptable and the consequences for undesirable behaviors. Reminiscence therapy (option A) is more effective in memory disorders. Emotive therapy (option B) and cognitive retraining (option D) are more effective with psychotherapy and other children.

59.**Answer: A**
Play therapy is especially useful for children under 12 because their developmental level makes them less able to verbalize thoughts and feelings. Learning to talk openly about themselves (option B), learning how to give and receive feedback (option C), and learning problem-solving skills (option D) are not the intended goals of play therapy. Those skills require more structured group and individual activities.

60.**Answer: C**
Childhood disorders that appear to be genetically transmitted include enuresis, autism, mental retardation, some language disorders, Tourette's syndrome, and attention deficit/hyperactivity disorder (ADHD). Anxiety (option A), sleepwalking (Option B), and mania (option D) do not appear to be genetically transmitted for children.

61.**Answer: C**
Because of shame, clients should be reluctant to talk about anxiety. Questions should be specific, direct, and individualized to the client. Option A is incorrect because when a client is experiencing anxiety abstract thinking and questions should be avoided. Option B and C are incorrect because the nurse should ask direct questions about the client's anxiety.

62.**Answer: D**
Safety needs generally have a higher priority than psychosocial needs. Option A, B, and C are applicable nursing diagnoses for anxious clients, but safety has the highest priority.

63.**Answer: B**
The goal of teaching calming techniques is to assist the client to learn to experience anxiety without feeling threatened and overwhelmed. Relaxation therapy does not assist a client to confront sources of anxiety. Likewise, keeping a journal is a self-monitoring technique but is not used to measure the outcome of relaxation. The goal is not to suppress feelings but to make them more manageable.

64.**Answer B**
Long-term goals for moderate anxiety should focus on assisting the client to understand the causes of anxiety and learn new coping strategies. These goals cannot be accomplished when the anxiety level is high because the client cannot focus on learning at this anxiety level.

65.**Answer: A**
To promote safety, nurses should stay with extremely anxious clients. During a panic attack a client is unable to focus on teaching. Physical activity should be avoided during a panic attach.

66.**Answer: B**
The overdose of alcohol and benzodiazepines is particularly lethal which demonstrates that the client is potentially harmful to self. The presenting personality may not be depressed, or may not have enough power to prevent the alter that is self-destructive from acting again, so substantial risk remain. Physical safety is priority over the other options.

67.**Answer: B**
The client needs to have physical needs met, including comfort, as the first priority. Creating a sense of safety after an assault is essential as anxiety may fluctuate. Although the other nursing interventions are relevant, they are not priorities and can be deferred to a later time.

68.**Answer: C**
Switching often occurs with increases in anxiety. Asking the client to explain more will help the nurse understand what is happening on a system level, and why the child alter was emergent. Option A and D will increase anxiety. Option B, although helpful, may not provide therapeutic outcome.

69.**Answer: C**
Amnesias are result o f being unable to cope with high levels of anxiety. There is no data to suggest other nursing diagnoses.

70.**Answer: A**
Reducing anxiety through the use of stress management techniques will prevent depersonalization that is a reaction to high levels of anxiety. There is no data to support suicidal thoughts or multiple identities. Improving self-concept is helpful, but is not a priority when anxiety leads to dissociation.

71.**Answer: B**
In a managed care system, the case manager is responsible for monitoring and ensuring of care, therefore collaborating with the treatment team. Although they provide different levels of care, both the staff nurse and the advanced practice primary care. A staff nurse involves supervision of other nursing personnel.

72.**Answer: B**
The nurse establishes the therapeutic relationship, which is a helping relationship, to assist the client in working on his needs and problems. Both medical and nursing diagnosis would be important in understanding the client. However, the nurse provides care for the person, not the diagnosis. Improving social interaction skills may be a focus of nursing intervention, but it is not the purpose of the relationship.

73.**Answer: C**
The purpose of therapeutic communication is to foster a helping relationship, so that the client can more effectively cope with problems. The other tasks described are part of the helping relationship but are not the overall purpose.

74.**Answer: D**
It is important for the nurse to frequently validate nurse-client communication to prevent cultural misunderstandings. Confronting noncompliance is inappropriate, because the nurse's interpretation of this situation may be quite different from the client's perspective. Therapeutic silence is importance; however, validating communication will ensure culturally sensitive care. Touch must be used in a cautious manner when trying to understand a client's probable response. Touch is not appropriate for all clients.

75.**Answer: D**
Reflection involves rewording the client's statement to indicate a nurses understanding of the client's experience.

76.**Answer: C**
It is important for the nurse to assess the individual's perception of the crisis and the events preceding the crisis situation. It is the individual's perception of a problem that determines the crisis. Determining the social support system is important; however, this assessment would occur following the description of the problem. Crisis intervention best occurs in logical, problem-solving sequence and therefore problem description would be the first step. The nurse calling the family to discuss the problem or referring the client to a bereavement support group are interventions that may or may not be appropriate, depending on the client's perception of the problem.

77.**Answer: C**
The problem-solving method is used in a systemic manner as part of crisis intervention. The behavioral approach or the nondirective approach would not be selected as part of crisis intervention. Although a supportive approach (e.g. supporting client strengths) is part of crisis intervention, the overall method guiding the nurse is the problem-solving approach.

78.**Answer: B**
The nurse works as a member of a health team and therefore needs to collaborate with other professionals in helping the individual resolve the crisis. The nurse may assist the client and may also teach the client; however, the question is asking for the nurse's role as a team member. The nurse may or may not be in a managerial role on the team.

79.**Answer: D**
The client who is in crisis has difficulty performing usual role in life because of the acute distress experienced. Somatic symptoms and poor concentration are also common because of the influence of the physiologic stress response. All of the remaining symptoms would commonly occur with the onset of a mental illness. They are not typical of the response of an individual to a crisis.

80.**Answer: D**
An important principle of crisis intervention is the strengthening and supporting of healthy aspects of an individual's functioning. This is important because the client needs to resolve the crisis and individual strengths aid coping. The remaining responses would be correct as general statements of rationale for a nurse assessing client strengths. However, in the situation of a crisis, the best rationale for the nurse identifying strengths is to aid in coping and therefore resolve crisis.

81.**Answer: D**
An individual who talks about suicide as a solution to problems is at high risk. Suicide threats need to be taken seriously, because this individual does not see any other viable solutions to problems in living. All of the factors in the other answer choices would increase the client's risk for depression; however, actual statements about intent for suicide are red flags for the nurse of imminent danger.

82.**Answer: C**
The nurse must act to safeguard the client from danger including self-harm. Implementation of specific agency protocol for suicide precautions would be protective for client. A client with suicide intent should not be left alone. One-to-one observations are generally part of suicide precautions. Encouraging the client to use problem solving and stimulating the client's interest in activities would be helpful for a client with depression; however, the priority intervention is to protect the client, and therefore the appropriate intervention is suicide precautions.

83.**Answer: D**
Individuals who develop mood disorders often have difficulty expressing feeling, especially feelings of anger toward significant others. Internalizing those feelings can contribute to loss of self-esteem and guilt, and therefore negative cognitions and depression. Ignoring problems is not a helpful strategy. Recognizing problems and using problem-solving methods will contribute to mental health. Antidepressants are certainly necessary in the treatment of the mood disorder of depression; however, they are not used in primary prevention. Crisis intervention would be a strategy useful in the immediate treatment of a crisis of a mood disorder. It is not a tool of primary prevention.

84.**Answer: C**
Assessment of the current family situation would include identifying the client's symptoms, duration of symptoms, and unique impact on this particular family The assessment data related to answer choices (option A) and (option B) would be important, but the immediate assessment would be more specific to the current family crisis. The quality of marital relationship would be one aspect of the entire family situation.

85.**Answer: A**
The most appropriate intervention when a client with mania begins to escalate is to remove the client from an over-stimulating environment. The community meeting is not an appropriate place for a client who is becoming agitated. The community group may be intimidated by client behavior and reluctant to intervene. The nurse is responsible for limit setting and intervention when client behavior is inappropriate. The community meeting is an important forum for client participation and should not be terminated because one client is upset. Removing the client from an overstimulating environment may be sufficient in helping a client regain self-control. The least restrictive means should be offered prior to use of chemical restraints.

86.**Answer: C**
The family's perception of the problem is essential because change in any one part of a family system affects all other parts and the system as a whole. Each member of the family has been affected by the current problems related to the school system and the nurse would be interested in this here-and-now data. The child's performance in school and the teacher's attempts to solve the problem are relevant and may be collected; however, priority would be given to the family's perception of the problem. The family education and work history may be relevant, but would not have priority.

87.**Answer: D**
The concept of triangles in a family system refers to the emotional configuration involving three family members or two members and an issue. In this situation, the conflict between the spouses is handled by deflecting attention away from the spouses and onto the child. Differentiation is the process of developing autonomy within the family system. Enmeshed relationship between spouses refers to over-involvement with the expectation that everyone in the family think and act alike. A skewed relationship between spouses refers to one spouse who is dysfunctional and therefore roles are imbalanced.

88.**Answer: B**
The parents are feeling responsible and this inappropriate self-blame can be limited by supplying them with the facts about the biologic basis of schizophrenia. Acknowledging the parent's responsibility is neither accurate nor helpful to the parents to reinforce blame. Support groups are useful; however, the nurse needs to handle the parent's self-blame directly instead of making a referral for this problem. Teaching the parents various ways they must change would reinforce the parental assumption of blame; although parents can learn about schizophrenia and what is helpful and not helpful, the approach suggested in this option implies the parents' behavior is at fault.

89.**Answer: C**
In families, the ability to discuss difficult issues openly among members reflects healthy behavior. Communication needs to be reciprocal between parents and children. Healthy, functional families are defined not by the absence of conflict but by the manner in which it is handled. The family needs to work out solutions, not have solutions provided by another.

90.**Answer: D**
There are several problems currently facing this family, including the father's disability, the mother's relapse, and the child's hospitalization. Mobilizing and using resources from both inside the family (strengths) and outside the family (support systems) will constitute the most appropriate outcome for the nursing diagnosis. Autonomy or differentiation of self takes place within the family system and does not mean that independence from the family system occurs. Ensuring the mother's compliance with alcohol treatment and identifying ownership of the problem as belonging to the parents are incorrect responses, because each member of the family is involved in the current problems.

91.**Answer: B**
Successful use of biofeedback enables the client to modify physiologic responses to stress, including blood pressure. A decreased need for an antihypertensive medication is an objective measurement of effectiveness. Although answer choices A and C are outcomes of stress management, they are not specific for biofeedback. Answer choice D would be a successful outcome of the medical treatment program.

92.**Answer: A**
Alternative treatment methods are often used as adjuncts to medical method, there is really no current scientific proof that these methods will work better than traditional medicine. This statement is quite global and therefore is not true. The other answer choice options are accurate regarding use of alternative treatment methods.

93.**Answer: C**
The client may experience increased anxiety during treatment and therefore may resume behaviors designed to prevent weight gain, such as vomiting or excessive exercise. Although the other answer choices are important areas for nursing intervention, they do not provide the rationale for remaining with a client for one hour after eating.

94. **Answer: C**
The physical need to reestablish near-normal weight takes priority because of the physiologic, life-threatening consequences of anorexia. The other answer choices are all important aspects of treatment, but they are not the highest priority in initial treatment.

95.**Answer: C**
Adolescents are not likely to feel free to ask questions and participate in a discussion if the nurse has a moralistic attitude toward sexual issues. Having an accepting, matter-of-fact, or nonjudgmental attitude will be helpful in allowing adolescents to feel comfortable discussing sexual issues.

96.**Answer: B**
Primary Prevention is directed towards health promotion and prevention of problems.
A – Tertiary Prevention is focused on rehabilitation and the reduction of residual effects of illness.
C – Secondary Prevention is related to early detection and treatment of problems
D – There is no category of prevention called therapeutic prevention

97.**Answer: A**
The father is siding with his daughter and supports her whereas the mother accuses her of negative behavior; this is an example of a coalition or alliance; both the mother and the father maybe in denial.
B. Resignation is evident when someone gives up.
C – Scapegoating is when an individual is labeled or blamed by other family members as the cause of the family's problems
D – Reaction formation is a defense mechanism that causes individuals to overtly behave in a manner that is exactly opposite to what they really feel in an attempt to conceal unacceptable feelings.

98.**Answer: A**
Without the development of trust, the child has little confidence that the significant other will return; separation is considered abandonment by the child.
B – Without identity, The individual will have a problem forming a social role and a sense of self; this results in identity diffusion and confusion
C – Without initiative, the individual will experience the development of guilt when curiosity and fantasy about sexual roles occur.
D – Without autonomy, the individual has little self confidence, develops a deep sense of shame and doubt, and learns to expect defeat.

99. **Answer: B**
The psychoanalytic model studies the unconscious and uses the strategies of hypnosis, dream interpretation, and free association as a means of releasing repressed feelings.
A – the behaviorist model subscribes to the belief that the self and mental symptoms are viewed as learned behaviors that persists because they are consciously rewarding to the individual; this model deals with behaviors on a conscious level of awareness.
C – the psychobiologic model views emotional and behavioral disturbances as stemming from a physical disease; abnormal behavior is directly attributed to a disease process; this model deals with behaviors on a conscious level of awareness.
D – the social – interpersonal model affirms that crucial social processes are involved in the development and resolution of disturbed behavior; this model deals with behavior on a conscious level of awareness.

100.**Answer: B**
The nurse must accept the client's statement and beliefs as real to the client to develop trust and move into a therapeutic relationship.
A – Clients can't be argued out of delusions
C – These feelings and thoughts are constant; this would result in an overdose.
D – Redirecting the client's conversation whenever negative topics are brought up adds to the client's feelings that negative thoughts are correct.