VERSION 1

ATI MENTAL HEALTH PROCTORED EXAM

1.) A nurse is providing teaching for a client who is scheduled to receive ECT for the treatment of major depressive disorder. Which of the following client statements indicates understanding of the teaching?
   a. "It is common to treat depression with ECT before trying medications."
   b. "I can have my depression cured if I receive a series of ECT treatments."
   c. "I should receive ECT once a week for 6 weeks."
   d. "I will receive a muscle relaxant to protect me from injury during ECT."

2.) A charge nurse is discussing TMS with a newly licensed nurse. Which of the following statements by the newly licensed nurse indicates an understanding of the teaching?
   a. "TMS is indicated for clients who have schizophrenia spectrum disorders."
   b. "I will provide postanesthesia care following TMS."
   c. "TMS treatments usually last 5 to 10 minutes."
   d. "I will schedule the client for daily TMS treatments for the first several weeks."

3.) A nurse is assessing a client immediately following an ECT procedure. Which of the following findings should the nurse expect? (Select all that apply.)
   a. Hypotension.
   b. Paralytic ileus.
   c. Memory loss.
   d. Nausea.
   e. Confusion.

4.) A nurse is leading a peer group discussion about the indications for ECT. Which of the following indications should the nurse include in the discussion?
   a. Borderline personality disorder.
   b. Acute withdrawal related to a substance use disorder.
   c. Bipolar disorder with rapid cycling.
   d. Dysphoric disorder.

A community mental health nurse is planning care to address the issue of depression among older adult clients in the community. Which of the following interventions should the nurse plan as a method of tertiary prevention?

A. Educating clients on health promotion techniques to reduce the risk of depression
B. Performing screenings for depression at community health programs
C. Establishing rehabilitation programs to decrease the effects of depression
D. Providing support groups for clients at risk for depression

A nurse is working in a community mental health facility. Which of the following services does this type of program provide? (Select all that apply)

A. Educational groups
B. Medication dispensing programs
C. Individual counseling programs
D. Detoxification programs
E. Family therapy

A nurse in an acute mental health facility is assisting with discharge planning for a client who has a severe mental illness and requires supervision much of the time. The client's wife works all day but is home by late afternoon. Which of the following strategies should the nurse suggest as appropriate follow-up care?

A. Receiving daily care from a home health aide
B. Having a weekly visit from a nurse case worker
C. Attending a partial hospitalization program
D. Visiting a community mental health center on a daily basis

D. Dry mouth
E. Irregular pulse

A nurse is providing teaching to an adolescent client who has a new prescription for clomipramine for OCD. Which of the following information should the nurse provide?

A. Eat a diet high in fiber
B. Check temperature daily
C. Take medication first thing in the morning before eating
D. Add extra calories to the diet as between-meal snacks

A nurse is providing teaching to an adolescent client who is to begin taking atomoxetine for ADHD. The nurse should instruct the client to monitor for which of the following adverse effects? (Select all that apply)

A. Somnolence
B. Yellowing skin
C. Increased appetite
D. Fever
E. Malaise

A nurse is caring for a school age child who has conduct disorder and a new prescription for methylphenidate transdermal patches. Which of the following information should the nurse provide about the medication?

A. Apply the patch once daily at bedtime
B. Place the patch carefully in a trash can after removal
C. Apply the transdermal patch to the anterior waist area
D. Remove the patch each day after 9 hr

A nurse is teaching a client who has intermittent explosive disorder about a new prescription for fluoxetine. Which of the following information should the nurse provide? (Select all that apply)

A. An adverse effect of this medication is CNS depression
B. Administer the medication in the morning
C. Monitor for weight loss while taking this medication
D. Therapeutic effects of this medication will take 1-3 weeks to fully

- Neuroleptic malignant syndrome (NMS): fever, dysrhythmias, BP fluctuations, muscle rigidity
- Others: agranulocytosis, anticholinergic effects, orthostatic hypotension, sedation, seizures

- Key points: monitor VS every 1-2 hours. Anticholinergics (benzotropine, diphenhydramine) can be used to control EPS symptoms. Muscle relaxant (dantrolene) can be used to NMS.

- Atypical
  - Risperidone (Risperdal)
    - Other atypical antipsychotic: clozapine, olanzapine
    - Indications: schizophrenia. Controls positive and negative symptoms (anergia, anhedonia, social withdrawal)
    - Side effects: diabetes, weight gain, increased cholesterol, sedation, orthostatic hypotension, anticholinergic effects, menorrhagia, decreased libido, clozapine carries risk for agranulocytosis
    - Key points: risperidone can be administered by IM injection 1 2 weeks (for non-compliant patients). Avoid alcohol.

ADHD medications

- Methylphenidate (Ritalin, Methylin)
  - Other ADHD medication: amphetamine mixture (Adderall)
  - Indications: ADHD and conduct disorders
  - Side effects: insomnia, dysrhythmias, decreased appetite, weight loss
  - Key points: do not administer at night, give medication immediately before or after meals, monitor childs weight during therapy.

Alcohol Abuse

- Medications during alcohol withdrawal
  - Benzodiazepines: chlordiazepoxide, diazepam, lorazepam – used to stabilize VS, decrease risk of seizures, decrease withdrawal manifestations
  - Carbamazepine: decrease risk of seizures
  - Clonidine: decreases autonomic response (decrease BP, HR)
  - Beta blockers: propranolol, atenolol – decreases autonomic response (decrease BP, HR) and craving
- Medications to promote abstinence

    - S&S: low body weight, low BP, decrease pulse, decreased body temperature, constipation, lanugo, mottled/cool extremities, poor skin turgor, amenorrhea
    - Criteria for hospitalization:
        - Weight loss > 30% over 6 months
        - Heart rate <40 /min
        - SBP <70 mmHg
        - Body temperature <36 degrees C
        - EKG abnormalities
        - Electrolyte imbalances
- Bulimia Nervosa
    - Eating disorder characterized by the ingestion of an abnormally large amount of food in short-term period, followed by an attempt to avoid gaining weight by purging what was consumed (though vomiting, diuretics, and/or enemas).
    - S&S: normal (or slightly higher) body weight calluses on knuckles (Russel's sign) from self-induced vomiting, enlargement of parotid gland, tooth erosion, hypokalemia, metabolic alkalosis (from vomiting) or metabolic acidosis (from laxative use)
- Eating Disorders: Nursing Care
    - Offer rewards for the amount of calories consumes, not the amount of weight gained.
    - Monitor VS, I/O, weight (weigh patient each morning before the intake of foods or fluids).
    - Restrict caffeine due to its stimulative and diuretic effects.
    - Provide a high-fiber diet to control constipation
    - Monitor and restrict the client's exercise
    - Provide small, frequent meals at scheduled times
    - Closely monitor patient during and after meals
- Somatic Symptom Disorder
    - Form a mental illness where the patient experiences physical manifestations that are the result of psychological factors (no underlying physical pathology). RT: conversion disorder.
    - Risk factors: female gender, teen/young adult, childhood trauma, mental illness (depression, anxiety, personality, disorder), recent stressful event.
    - Nursing care: acknowledge symptoms as being real to the patients

1. A nurse is preparing to provide an educational seminar on stress to other nursing staff. Which of the following information should the nurse include in the discussion?
   A. excessive stressors cause the client to experience distress. Distress is the result of excessive or damaging stressors, such as anxiety or anger.

2. A nurse is discussing acute vs. prolonged stress with a client. Which of the following effects should the nurse identify as an acute stress response? (Select all that apply.)
   B. Depressed immune system
   C. Increased blood pressure
   E. Unhappiness

3. A nurse is teaching a client about stress-reduction techniques. Which of the following client statements indicates understanding of the teaching?
   A. “Cognitive reframing will help me change my irrational thoughts to something positive.” Cognitive reframing helps the client look at irrational cognitions (thoughts) in a more realistic light and to restructure those thoughts in a more positive way.

4. A client says she is experiencing increased stress because her significant other is “pressuringme and my kids to go live with him. I love him, but I’m notready to do that.” Which of the following recommendations should the nurse make to promote a change in the client’s situation?
   B. Use assertiveness techniques. Assertive communication allows the client to assert her feelings and then make a change in the situation.

5. A nurse is caring for a client who states, “I’m so stressed at work because of my coworker. He expects me to finish his work because he’s too lazy!” When discussing effective communication, which of the following statementsby the client to his coworker indicates client understanding?
   D. “When I have to pick upextra work, I feel very overwhelmed. I need to focus on my own responsibilities.” This response demonstrates assertive communication, which allows the client to state his feelings about the behavior and then promote a change.

Chapter 10 – Brain stimulation Therapies

1. A nurse is providing teaching for a client who is scheduled to receive eCt for the treatment of major depressive disorder. Which of the following client statements indicates understanding of the teaching?

d. "I will schedule the client for daily TMS treatments for the first several weeks."

8.) A nurse is assessing a client immediately following an ECT procedure. Which of the following findings should the nurse expect? (Select all that apply.)
   a. Hypotension.
   b. Paralytic ileus.
   c. Memory loss.
   d. Nausea.
   e. Confusion.

9.) A nurse is leading a peer group discussion about the indications for ECT. Which of the following indications should the nurse include in the discussion?
   a. Borderline personality disorder.
   b. Acute withdrawal related to a substance use disorder.
   c. Bipolar disorder with rapid cycling.
   d. Dysphoric disorder.

10.) A nurse is planning care for a client following surgical implantation of a VNS device. The nurse should plan to monitor for which of the following adverse effects? (Select all that apply.)
   a. Voice changes.
   b. Seizure activity.
   c. Disorientation.
   d. Dysphagia.
   e. Neck pain.

Chapter 16 Personality Disorders

6.) A nurse manager is discussing the care of a client who has a personality disorder with a newly licensed nurse. Which of the following statements by the newly licensed nurse indicates an understanding of the teaching?
   a. "I can promote my client's sense of control by establishing a schedule."
   b. "I should encourage clients who have a schizoid personality disorder to increase socialization."
   c. "I should practice limit-setting to help prevent client manipulation."
   d. "I should implement assertiveness training with clients who have antisocial personality disorder."

7.) A nurse is caring for a client who has avoidant personality disorder. Which of the following statements is expected from a client who has this type of personality disorder?
   a. "I'm scared that you're going to leave me."
   b. "I'll go to group therapy if you'll let me smoke."
   c. "I need to feel that everyone admires me."
   d. "I sometimes feel better if I cut myself."

8.) A nurse is caring for a client who has borderline personality disorder. The client says, "The nurse on the evening shift is always nice! You are the meanest nurse ever!" The

D. "Medication and psychotherapy are most effective during the acute phase of MDD."

A nurse is interviewing a 25-year-old client who has a new diagnosis of dysthymic disorder. Which of the following findings should the nurse expect?

A. Wide fluctuations of mood
B. Report of a minimum of 5 clinical findings of depression
C. Presence of manifestations for at least 2 years
D. Inflated sense of self-esteem

A nurse is planning care for a client who has bipolar disorder and is experiencing a manic episode. Which of the following interventions should the nurse include in the plan of care? (Select all that apply)

A. Provide flexible client behavior expectations
B. Offer concise explanations
C. Establish consistent limits
D. Disregard client complaints
E. Use a firm approach with communication

A nurse is teaching a newly licensed nurse about the use of ECT for the treatment of bipolar disorder. Which of the following statements by the newly licensed nurse indicates understanding?

A. "ECT is the recommended initial treatment for bipolar disorder."
B. "ECT is contraindicated for clients who have suicidal ideation."
C. "ECT is effective for client's who are experiencing severe mania."
D. "ECT is prescribed to prevent relapse of bipolar behavior."

A nurse is caring for a client who has bipolar disorder. The client states, "I am very rich, and I feel I must give my money to you." Which of the following responses should the nurse make?

A. "Why do you think you feel the need to give money away?"
B. "I am here to provide care and cannot accept this from you."
C. "I can request that your case manager discuss appropriate charity

A nurse is caring for an adult client who has injuries resulting from intimate partner abuse. The client does not wish to report the violence to law enforcement authorities. Which of the following nursing actions is the highest priority?

A. Advise the client about the location of women's shelters
B. Encourage the client to participate in a support group for survivors of abuse
C. Implement case management to coordinate community and social services
D. Educate the client about the use of stress management techniques

A nurse is discussing silent rape reaction with a newly licensed nurse. The nurse should identify which of the following characteristics as expected for this type of reaction? (Select all that apply)

A. Sudden development of phobias
B. Development of substance use disorder
C. Increased level of anxiety during interview
D. Reactivation of a prior physical disorder
E. Unwillingness to discuss the sexual assault

A nurse is assessing a client who experienced sexual assault. Which of the following findings indicate the client is experiencing an emotional reaction of rape-trauma syndrome? (Select all that apply)

A. Genitourinary soreness
B. Difficulties with low self-esteem
C. Sleep disturbances
D. Emotional outburst
E. Difficulty making decisions

A nurse is discussing the care of a client following a sexual assault with a newly licensed nurse. Which of the following statements by the newly licensed nurse indicates an understanding of the teaching?

A. "I will administer prophylactic treatment for sexually transmitted infections."
B. "I am not required to obtain informed consent before the sexual assault

    - Occurs across all economic/education levels.
- Family Violence
    - Cycle of violence
        - Tension-building phase: minor episodes of anger, verbal abuse, vulnerable person is tense
        - Acute battering phase: serious abuse takes place
        - Honeymoon phase: abuser becomes loving is sorry for behavior. Abuser promises to change.
        - **after honeymoon phase, cycle beings again and again with periods of escalation and de-escalation (decreasing time between two over time)
- Types of Violence
    - Physical violence: physical harm is directed towards another child (ex: child, intimate partner, older adult at home)
    - Sexual violence: sexual contact w/out consent
    - Neglect: failure to provide physical care (ex: food, clean clothes), emotional care (ex: interaction w/ child), education, and/or health care.
    - Economic maltreatment: failure to provide for needs of vulnerable person when funds are available
- Signs of abuse
    - Infants:
        - Signs of shaken baby syndrome: respiratory distress, bulging fontanels, increase in head circumference
        - Bruising on infants under 6 months of age
    - Preschoolers and older:
        - Unusual location of bruising (abdomen, back, buttocks). Note: bruising is expected on arms, legs
        - Bruises in different stages of healing
        - Forearm spiral fractures
        - Presence of multiple fractures
        - Small round burns (possibly cigarettes)
        - Burns covering hands or feet (possibly from immersion in boiling water)
- Sexual assault
    - Forced sexual contact. It is a crime of violence, aggression, and power (NOT a crime of passion)

It is recommended to obtain baseline levels and then repeat every 2 months during the first 6 months of therapy.

17. A nurse is teaching a client who has Agoraphobia about Systematic Desensitization. Which of the following comments should the nurse include in the teaching?

a. "You will watch from a secure location as your therapist goes to public spaces."

The nurse should recognize that encouraging the client to watch as the therapist acts as a role model in anxiety-provoking situations is an example of modeling, not systematic desensitization.

b. "You will start your therapy by staying in a public space until your anxiety decreases."

The nurse should recognize that sudden exposure of the client to the undesirable stimulus is an example of flooding, not systematic desensitization.

c. "You will be instructed to say 'Stop!' out loud when you become anxious in public spaces."

The nurse should recognize that saying "Stop!" to interrupt a negative thought is an example of thought stopping, not systematic desensitization.

CORRECT

d. "You will slowly be exposed to increasing levels of public spaces."

The nurse should inform the client that, using systematic desensitization, she will be gradually exposed to the feared situation under controlled conditions until she learns to overcome the anxious response.

18. A nurse is planning a staff education session about the administration of antidepressant medications to older adult clients. Which of the following information should the nurse include in the teaching?

CORRECT

a. Older adult clients require a lower initial dose of antidepressant medication than adult clients.

The nurse should recognize that older adult clients are recommended to start at half the adult dose for antidepressant medications. This is due to altered rates of absorption and the increased risk for adverse effects.

b. Older adult clients should not receive antidepressant medication.

The nurse should identify that antidepressant medications are commonly prescribed for older adult clients; however, adjustments are needed due to the clients' altered rates of absorption.

37) A nurse in a mental health facility is caring for a newly admitted client. Which of the following resources should the nurse recommend to help the client adapt to the health care setting?

a. A community meeting
b. A medication group
c. A self-help meeting
d. A symptom-management group

38) A nurse is assisting with obtaining informed consent for a client who has been declared legally incompetent. Which of the following actions should the nurse take?

a. Request that the client's guardian sign the consent
b. Ask the charge nurse to obtain informed consent
c. Contact the facility social worker to obtain the consent
d. Explain implied consent to the client's family

39) A nurse is caring for a client who has cocaine use disorder. Which of the following manifestations should the nurse expect the client to have during withdrawal?

a. Hand tremors
b. Rapid speech
c. Fatigue
d. Seizures

40) A nurse is providing teaching about disorder management for a client who has posttraumatic stress disorder (PTSD). Which of the following statements should the nurse include in the teaching?

a. "Avoiding stimuli that trigger memories of the trauma can help you overcome your PTSD"
b. "Talking about the traumatic experience is recommended"
c. "Response prevention is an effective treatment for PTSD"
d. "You should try to limit the number of hours that you sleep each day"

41) A nurse is assessing a client who has bipolar disorder and is taking lamtropine. Which of the following findings is the nurse's priority?

a. Thyroid-stimulating hormone (TSH) 4.0 microunits/mL
b. Alanine transaminase (ALT) 20 IU/L
c. Skin rash
d. Epistaxis

c. Physical therapist
d. Social worker

68. A nurse is caring for a group of clients on a mental health unit. For which of the following clients is the nurse mandated to report to the appropriate agency?
    a. A client who reports that she took $20 from the cash register where she works
    b. A client who reports that her partner ties their child to a bed as punishment
    c. A client who reports that he enjoys smoking marijuana on weekends
    d. A client who reports lying to his provider about having suicidal ideation
69. A nurse is obtaining a medical history from a client who is requesting a prescription for bupropion for smoking cessation. Which of the following assessment findings in the client's history should the nurse report to the provider?
    a. Recent head injury
    b. Hepatitis B infection
    c. Hypothyroidism
    d. Knee arthroplasty 1 month ago
70. A charge nurse is orienting a newly licensed nurse and observes the newly licensed nurse imitating her behaviors. The nurse should recognize this behavior as which of the following defense mechanisms?
    a. Suppression
    b. Reaction formation
    c. Identification
    d. Compensation

71. A nurse is caring for a school-aged child who has conduct disorder and is being physically aggressive toward other children in the unit. Which of the following actions should the nurse take first?
    a. Place the child in seclusion
    b. Use therapeutic hold technique
    c. Apply wrist restraints
    d. Administer risperidone

a. Clinical nurse specialist
b. Recreational therapist
c. Social worker
d. Occupational therapist

134. A nurse is providing crisis intervention for a client who was involved in a violent mass casualty situation in the community. Which of the following actions should the nurse take during the initial session with the client?
a. Encourage the client to display anger toward the cause of the crisis
b. Tell the client that his life will soon return to normal
c. Identify the client's usual coping style
d. Help the client focus on a wide variety of topics regarding the crisis

135. A nurse is planning to conduct a support group for adolescents who have cancer. Which of the following actions should the nurse include during the orientation phase?
a. Manage conflict within the group
b. Establish rapport with group members
c. Encourage the use of problem-solving skills
d. Maintain the group's focus on identified issues

136. A nurse is assessing a client who recently started antidepressant therapy for the treatment of major depressive disorder. Which of the following findings indicates the client is at an increased risk for suicide?
a. Increased energy
b. Hypersomnia
c. Unkempt appearance
d. Psychomotor retardation

137. A nurse in a rehabilitation unit is caring for a client who has a traumatic brain injury. To which of the following members of the client's interprofessional team should the nurse refer the client in order to help him relearn how to use eating utensils?
a. Neuropsychiatrist
b. Occupational therapist
c. Physical therapist
d. Social worker

feeding disorders, epilepsy, and/or *allergies*.

- There is a wide variability in functioning. Abilities can range from *poor* (inability to perform self-are, inability to communicate and relate to others) to *high* (ability to function at near normal levels).

Mental Health

Delirium	**Dementia**
Rapid onset over short period of time	Chronic, gradual, progressive deterioration of the cognitive process
Altered level of conscious is common	Level of consciousness not altered
Impairments may fluctuate throughout day	Impairments do not fluctuate throughout day
Impaired memory, focus, judgment, ability to calculate	Impaired memory, focus, judgment, ability to calculate
Restlessness, agitation, sundowning may increase/decrease daily	Restlessness, agitation, sundowning remain stable
Vital sign may be unstable due to underlying cause	Vital signs are usually stable unless an illness is present
Rapid personality changes and may experience hallucinations and illusions	Mostly result from chronic disease like Alzheimer or alcohol abuse & can result from trauma
Reversible if diagnosed and treated promptly	Irreversible and progressive
Frequently has an identifiable cause	Has three stages- mild, moderate, and severe

Mental health nursing is an important role in the world of nursing and is essential in promoting and supporting a person's mental health recovery and enabling them to have more involvement and control over their condition.

Tricyclic antidepressants - Amitriptyline

Selective serotonin reuptake inhibitors – Fluoxetine