Chapter 15 Pre Test

Smith,Crystal

Submitted: 3/21/2011 12:47:48 PM **Grade:** 14.8% **Attempt Number:** 1/3 **Questions Attempted:** 27/27

1. **A nurse working at the crisis center takes a call from a client. The client states he has a history of depression and has been feeling down for the last 2 months. He is separated from his spouse and is feeling alone. He states that he "drinks" and has several legal problems related to driving under the influence. The nurse should assess for the presence of what symptom?**
   a. Hypomania
   b. Suicidal ideation
   c. Delirium tremens
   d. Homicidal ideation

   Grade: 0
   User Responses: d.Homicidal ideation
   Feedback: a.Rationale: Suicide is attempted by 15% of alcoholics and presents a dangerous risk for a client with a history of depression and alcohol dependence. The symptoms of depressed mood, spousal separation, and legal problems are all stressors that represent loss in the client's life and increase his risk for suicide. Delirium tremens is a symptom of major withdrawal. There is no evidence of homicidal ideation. Hypomania is an elevation of mood.
   Cognitive Level: Analysis
   Nursing Process: Assessment
   Client Need: Safe, Effective Care Environment

2. **A nursing student asks the staff nurse how the presence of a substance abuse disorder impacts the treatment of a coexisting psychiatric disorder. What is the best explanation of the impact?**
   a. Psychiatric treatment is hindered if clients are under the influence of drugs or alcohol.
   b. Substance abuse treatment must be prioritized over psychiatric treatment.
   c. Psychiatric treatment must be prioritized over substance abuse treatment.
   d. There is little to no impact on treatment.

   Grade: 0
   User Responses: d.There is little to no impact on treatment.
   Feedback: a.Rationale: Comorbid substance abuse is a common problem seen in psychiatric clients. Substance abuse offers psychiatric clients escape from poor coping skills, heightened stress, economic factors, and the demoralizing effects of their illness. Clients with psychiatric and substance abuse problems require specialized treatment that addresses both problems equally.
   Cognitive Level: Evaluation
   Nursing Process: Assessment
   Client Need: Psychosocial Integrity

3. **A client with a diagnosis of bipolar disorder and alcohol dependence is admitted to the inpatient psychiatric unit. What behaviors on the part of the nursing staff could be considered enabling behaviors?**
   a. Presenting health information related to alcohol abuse
   b. Helping the client orient to the unit rules
   c. Confronting the client about denial
   d. Agreeing with the client's reasons for using alcohol

Grade: 1
User Responses: d.Agreeing with the client's reasons for using alcohol
Feedback: a.Rationale: Agreeing with the client's reasons for using alcohol is an enabling behavior that denies the seriousness of the client's substance abuse problem. Helping the client orient to the unit rules and providing health teaching are therapeutic interventions. Confrontation strategies are used to break down a substance abuser's denial.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Psychosocial Integrity

4. **An adolescent client presented to the emergency room after ingesting LSD that produced a bad trip. The drug's effects wore off after 10 hours. What health teaching should be provided to the client before discharge?**
   a. Information about the carcinogenic effects of marijuana
   b. Information about the risks of narcotic use
   c. Information about flashbacks
   d. Information about the risks of cocaine use

Grade: 0
User Responses: d.Information about the risks of cocaine use
Feedback: a.Rationale: Flashbacks are a spontaneous reliving of the experiences the person felt while under the influence of LSD. The client should be made aware that flashbacks are a common side effect of hallucinogenic drugs. Information about narcotic use, cocaine use, and marijuana use is inappropriate at this time as there is no data to suggest that the client is using these substances.
Cognitive Level: Application
Nursing Process: Planning
Client Need: Psychosocial Integrity

5. **A client is seen in the ambulatory care clinic. She is irritable, thin, and jittery, and has dilated pupils. She states to the nurse that she has been up for days speeding along and now she is crashing. Her vital signs are elevated: pulse is 100 and oral temperature is 103oF. She states her belief that the nursing staff is out to get her. The client is most likely under the influence of which substance?**
   a. Amphetamine
   b. Heroin
   c. Barbiturate
   d. Marijuana

Grade: 0
User Responses: d.Marijuana

Feedback: a.Rationale: The physical symptoms are consistent with amphetamine abuse. The paranoia and irritability are also signs of amphetamine use. Barbiturates,marijuana, and heroin produce symptoms marked by drowsiness and CNS depression.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Physiological Integrity

6. **If untreated, alcohol withdrawal follows which progression of symptoms?**
   a. Hallucinations, delirium tremens, tremulousness
   b. Tremulousness, delirium tremens, hallucinations
   c. Tremulousness, hallucinations, delirium tremens
   d. Delirium tremens, hallucinations, tremulousness

Grade: 0
User Responses: d.Delirium tremens, hallucinations, tremulousness
Feedback: a.Rationale: The progression of symptoms in untreated alcohol withdrawal starts with the onset of tremulousness and hallucinations. These symptoms peak about 24 hours after the last drink. Delirium tremens peaks about 24–48 hours after the last drink.
Cognitive Level: Synthesis
Nursing Process: Assessment
Client Need: Physiological Integrity

7. **A client with a diagnosis of alcohol dependence has been in an alcohol rehabilitation center. Which behaviors would indicate that the treatment plan has been effective?**
   a. The client is attending daily Alcoholic Anonymous meetings and has made many new friends whom she is trying to find jobs for at her place of employment.
   b. The client has been sober for 12 days, states she is working on staying clean one day at a time, and has made arrangements to return to work part-time in 2 weeks.
   c. The client has been sober for 16 days, states she has her drinking problems under control, and is looking for a new job.
   d. The client has been sober for 20 days, states she will no longer drink at work or on weekdays, and plans to stop by her favorite bar to see her old friends.

Grade: 0
User Responses: d.The client has been sober for 20 days, states she will no longer drink at work or on weekdays, and plans to stop by her favorite bar to see her old friends.
Feedback: a.Rationale: The client who has been sober for 12 days, states she is working on staying clean one day at a time, and has made arrangements to return to work part-time in 2 weeks is displaying adherence to the principles of Alcoholics Anonymous. This approach may help her stay sober. The overconfident statements about her drinking problem being under control, looking for a new job, not drinking at work or on weekdays, and planning to stop by her favorite bar to see her old friends are all indicative of early relapse. The client may be attending daily Alcoholic Anonymous meetings but is engaging in codependent behaviors through trying to find jobs for her new friends at her place of employment.
Cognitive Level: Analysis
Nursing Process: Evaluation
Client Need: Psychosocial Integrity

8. **A nurse works in a drug treatment facility and conducts the weekly family support group. A family member expresses how much the group has helped her cope, but she is worried about how she will cope after her husband's discharge. Which of the following statements would be most appropriate for the nurse to communicate to this family member?**
   a. "Al-Anon would be a good group for you to attend."
   b. "You can attend this support group indefinitely."
   c. "I am sure that everything will work out."
   d. "Let's talk more about your feelings."

Grade: 0
User Responses: d."Let's talk more about your feelings."
Feedback: a.Rationale: It is important that the nurse refer the family member to Al-Anon or another support group specifically designed to help families cope with the impact of substance abuse. The family member will not be able to attend the inpatient family support group indefinitely. While it is important to openly discuss feelings, the family member has clearly stated her concerns. Stating that things will work out is not therapeutic and minimizes the family member's concerns.
Cognitive Level: Evaluation
Nursing Process: Implementation
Client Need: Psychosocial Integrity

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9. **A surgical nurse notes that a client is having multiple elective procedures. Closer examination of the client's record reveals that the client is a recovering substance abuser. What would be the most appropriate action by the nurse?**
   a. Assess the client's intent and follow-up behaviors for the surgeries.
   b. Set strict limits on how many times the client can have surgery.
   c. Encourage the postoperative staff to restrict pain medications for the client.
   d. Explain to the surgeon that the history of substance abuse makes the client a poor candidate for surgery.

Grade: 0
User Responses: d.Explain to the surgeon that the history of substance abuse makes the client a poor candidate for surgery.
Feedback: a.Rationale: It is important to assess the client's intent and follow-up behaviors for the elective surgeries. The evaluation should include assessment for substance dependence in the form of prescription pain medication overuse or dependence. It is important to point out to the surgeon the client's history of substance abuse, but it is the surgeon's role to decide who is a candidate for surgery. It would be inappropriate for the nurse to encourage the postoperative staff to restrict pain medications for the client or to set strict limits on how many times the client can have surgery.
Cognitive Level: Evaluation
Nursing Process: Assessment
Client Need: Psychosocial Integrity

10. **A client with a diagnosis of alcohol dependence is prescribed the agonist medication disulfiram (Antabuse). Which priority teaching should the nurse provide for this client?**
   a. Take the medication with food.
   b. Avoid the ingestion of any products that contain tyramine.
   c. Avoid the ingestion of any products that contain alcohol.
   d. Take the medication at the same time daily.

Grade: 0
User Responses: d.Take the medication at the same time daily.
Feedback: a.Rationale: The client should be taught that disulfiram inhibits acetaldehyde dehydrogenase, which normally metabolizes acetaldehyde. As a result, acetaldehyde will accumulate if alcohol is ingested. Acetaldehyde is highly toxic and produces symptoms of nausea, hypotension, vomiting, flushing, dizziness, and tachycardia. The client must be instructed orally and in writing to avoid use of all forms of alcohol, including over-the-counter cough and cold remedies and mouthwash. Dietary tyramine restriction is appropriate if the client is using monoamine oxidase inhibitors. Taking disulfiram with food or at the same time daily is not necessary.
Cognitive Level: Application
Nursing Process: Planning
Client Need: Physiological Integrity

11. **The nurse is discussing treatment choices for the family of a client diagnosed with narcotic dependence. Which treatment option would be appropriate for the family of the client?**
    a. Women for Sobriety
    b. Rational Recovery
    c. Narcotics Anonymous
    d. Al-Anon

    Grade: 1
    User Responses: d.Al-Anon
    Feedback: a.Rationale: Substance abuse affects the entire family. Al-Anon is a twelve-step program that helps the family clarify the problems related to the substance abuse and presents possible solutions. Al-Anon also provides the family with a support system. Rational Recovery and Women for Sobriety are non-spiritual-based treatment options for clients with substance abuse problems. Narcotics Anonymous is a twelve-step spiritual self-help program.
    Cognitive Level: Application
    Nursing Process: Planning
    Client Need: Psychosocial Integrity

12. **Clients who abuse cocaine report strong cravings for the drug and the experience of post-coke blues following the high. Which treatment for cocaine dependence would address these symptoms?**
    a. Amino acid treatment
    b. Synaptic treatment
    c. Detoxification
    d. Benzodiazepine treatment

    Grade: 0
    User Responses: d.Benzodiazepine treatment
    Feedback: a.Rationale: Synaptic treatment involves the use of tricyclic antidepressants like imipramine hydrochloride (Tofranil) to build up the level of neurotransmitters that were depleted by cocaine use. Detoxification refers to the process of removing the drug's presence from the client's system. Benzodiazepine treatment is sometimes given during detoxification. Amino acid treatment, which involved the use of tryptophan to replace neurotransmitters that were depleted by cocaine abuse, is no longer used because of deaths associated with it.
    Cognitive Level: Application
    Nursing Process: Implementation
    Client Need: Physiological Integrity

13. **A client has a 20-year history of heavy alcohol consumption (diagnosis of alcohol dependence) and has recently developed delusions, memory deficits, and increasingly confused behavior. Based on the presenting data, an appropriate nursing diagnosis for this individual would include:**
    a. Disturbed thought processes related to the physiologic alterations of neurologic functioning.
    b. Risk for injury related to the untoward effects of alcohol on the body.
    c. Ineffective coping related to the denial of an alcohol problem.
    d. Defensive coping related to a genetic drinking disorder.

Grade: 0
User Responses: d.Defensive coping related to a genetic drinking disorder.
Feedback: a.Rationale: Delusions, memory deficits, and confusion are symptoms indicative of a nursing diagnosis of disturbed thought processes. Defensive coping is a nursing diagnosis for clients who project false positive self-evaluations. Ineffective coping addresses drinking behavior, but not the current symptoms. Risk for injury should be related to the current symptoms.
Cognitive Level: Application
Nursing Process: Diagnosis
Client Need: Physiological Integrity

14. **A nurse develops community-wide education programs for adolescents about the risks of smoking. According to the Transtheoretical Model of Behavior Change, what stage of change is the nurse attempting to prompt?**
a. Precontemplation
b. Maintenance
c. Contemplation
d. Action

Grade: 0
User Responses: d.Action
Feedback: a.Rationale: According to the Transtheoretical Model of Behavior Change, during the contemplation stage there is awareness of the benefits of change. During the precontemplation stage, the client does not intend to change behavior. During the action stage, the client overtly modifies behavior. During the maintenance stage, the client works to prevent relapse.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Health Promotion and Maintenance

15. **Which of the following symptoms is correlated with the neurological complications of long-term alcohol abuse?**
a. Lack of coordination
b. Talkativeness
c. Slurred speech
d. Memory loss

Grade: 1
User Responses: d.Memory loss
Feedback: a.Rationale: Memory loss is a neurologic symptom of Korsakoff's syndrome and Wernicke's encephalopathy. Slurred speech, lack of coordination, and talkativeness are all symptoms of alcohol intoxication.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Psychosocial Integrity

16. **A client in alcohol rehabilitation tells the nurse, "I've got this booze thing under control." The nurse realizes that the client is at risk for which of the following situations?**
    a. Relapse
    b. Codependence
    c. Enabling
    d. Powerlessness

    Grade: 0
    User Responses: d.Powerlessness
    Feedback: a.Rationale: The client is at risk for relapse. This attitude may lead the client to put himself in situations in which others are using alcohol. Codependence occurs when an individual allows another person's behavior to affect him while being obsessed with the other person's behavior. Powerlessness is the first step of the Alcoholics Anonymous twelve-step program. Enabling by others perpetuates the alcoholic's drinking behaviors.
    Cognitive Level: Application
    Nursing Process: Assessment
    Client Need: Psychosocial Integrity

17. **Which of the following treatment approaches would be most appropriate in helping a client maintain long-term smoking cessation?**
    a. Nicotine gum
    b. Bupropion (Zyban)
    c. Counseling
    d. Nicotine patch

    Grade: 0
    User Responses: d.Nicotine patch
    Feedback: a.Rationale: Counseling with an emphasis on relapse prevention is effective for long-term abstinence. The nicotine patch and nicotine gum are short-term approaches that maintain the level of nicotine in the bloodstream. Bupropion (Zyban) is an antidepressant that is effective for short-term abstinence.
    Cognitive Level: Application
    Nursing Process: Implementation
    Client Need: Physiological Integrity

18. **A client diagnosed with methamphetamine dependence is planning to move in with some of his old " druggie" friends after his discharge from the drug treatment facility. Which of the following statements would be most appropriate for the nurse to communicate to the client?**
    a. "That should help you get on track financially."
    b. "Relapse is always a threat. You need to consider making changes to your lifestyle if you want to stay clean."
    c. "I think you should move in with your parents."
    d. "You'll be back here before you know it."

Grade: 0
User Responses: d."You'll be back here before you know it."
Feedback: a.Rationale: Relapse is always a threat for a client with substance dependence. The client needs to realize that living with friends who abuse drugs could trigger a relapse. The nurse's role is to assist the client to explore different coping strategies and ways to alter destructive behaviors. Statements that the client will be back or that living with these friends is a good financial decision are nontherapeutic. The client, not the nurse, needs to make the decisions about his lifestyle change.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Psychosocial Integrity

19. **The nurse anticipates that a client who has sedative hypnotic dependence will experience withdrawal symptoms. The nurse should assess for the onset of which set of symptoms?**
a. Nausea and vomiting, sweating, anxiety, and coarse tremors
b. Craving, hypersomnia, irritability
c. Depression, restlessness, disorientation
d. Runny nose, diarrhea, yawning

Grade: 0
User Responses: d.Runny nose, diarrhea, yawning
Feedback: a.Rationale: Nausea and vomiting, sweating, anxiety, and coarse tremors are withdrawal symptoms of sedative hypnotics. Runny nose, diarrhea, and yawning are withdrawal symptoms of opioids. Depression, restlessness, and disorientation are withdrawal symptoms of amphetamines. Craving, hypersomnia, and irritability are withdrawal symptoms of cocaine.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Psychosocial Integrity

20. **A client in the delirium tremens stage of alcohol withdrawal is experiencing auditory and visual hallucinations, disorientation, and clouded consciousness. Which priority nursing intervention should the nurse plan to implement?**
a. A dimly lit room
b. One-to-one supervision
c. Fluid restrictions
d. Five-minute checks

Grade: 0
User Responses: d.Five-minute checks
Feedback: a.Rationale: Safety is a priority for a client in delirium tremens. One-to-one supervision is necessary to promote physical safety. A dimly lit room may promote illusions. Placing the client on fluid restrictions is not necessary unless there is evidence of fluid overload. Five-minute checks are not sufficient to promote safety.
Cognitive Level: Application
Nursing Process: Planning
Client Need: Safe, Effective Care Environment

21. **An unconscious client is brought to the emergency room following an overdose of pentobarbital (Nembutal). What should be the nurse's first action?**
a. Check pupils.
b. Establish an airway.
c. Test reflexes.
d. Initiate vomiting.

Grade: 0
User Responses: d.Initiate vomiting.
Feedback: a.Rationale: Establishing an airway is a priority for an unconscious client. Vomiting should not be induced in an unconscious client due to the danger of aspiration. Pupil and reflex checks are neurological assessments that are necessary, but not a priority.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Physiological Integrity

22. **A client tells the nurse, "I can't help myself. I'm an alcoholic and can't control my drinking." The client is using what defense mechanism?**
a. Denial
b. Projection
c. Regression
d. Rationalization

Grade: 1
User Responses: d.Rationalization
Feedback: a.Rationale: The client is using rationalization by making excuses and not taking responsibility for the behavior. In denial the client would say there was no problem. Projection would have the client using blaming behavior. Regression would have the client returning to an earlier stage of development.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Psychosocial Integrity

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23. **A volunteer assigned to observe in a chemical dependency center asks, "What's the difference between drug abuse and drug dependence?" The nurse replies, "Abuse implies maladaptive consistent use of the drug despite experiencing problems related to the drug." Which statement should be used to complete the answer?**
    a. Dependence refers to synergistic effects.
    b. Dependence involves impaired control of drug use, development of tolerance, and withdrawal symptoms occurring when intake is reduced or stopped.
    c. Dependence occurs when drug use interferes with neurotransmitter transmission.
    d. Dependence refers to antagonistic effects.

    Grade: 0
    User Responses: d.Dependence refers to antagonistic effects.
    Feedback: a.Rationale: Dependence involves impaired control of drug use, development of tolerance, and withdrawal symptoms occurring when intake is reduced or stopped. It is possible to abuse substances but not be dependent on them.
    Cognitive Level: Evaluation
    Nursing Process: Assessment
    Client Need: Physiological Integrity

24. **A client uses alcohol to help her relax and relieve stress. When she first began to use alcohol, two drinks made her feel relaxed and sleepy. Now, after a year, she needs four drinks to achieve the same effect. The nurse knows the reason for this is:**
    a. She has developed tolerance.
    b. She is experiencing more stress.
    c. She needs to switch her brand of alcohol.
    d. She has hyposensitivity to alcohol.

    Grade: 0
    User Responses: d.She has hyposensitivity to alcohol.
    Feedback: a.Rationale: Tolerance is the need for higher and higher doses of the drug to achieve the same effect. Switching her brand of alcohol will not change her tolerance. The client is not hyposensitive to alcohol. It is not possible to assess her stress level.
    Cognitive Level: Analysis
    Nursing Process: Assessment
    Client Need: Physiological Integrity

25. **A nurse who works in the emergency department is feeling exhausted and frustrated with her job. She states she is tired of dealing with drug-seeking addicts day after day. What behavior would be most appropriate to address these feelings?**
    a. Start to explore other employment options.
    b. Limit client interaction.
    c. Discuss her concerns with clinical supervisor.
    d. Put in for some time off from work.

Grade: 0
User Responses: d.Put in for some time off from work.
Feedback: a.Rationale: It is important that the nurse understand that substance abuse is a disease with exacerbations and remissions. The nurse should understand that progress may be slow and setbacks inevitable despite the best efforts of the nurse and the client. Viewing substance abuse in this way may help the nurse avoid surrendering to frustration. Vacationing, quitting, or limiting client interactions are avoidance techniques that do not appropriately address the nurse's feelings of frustration and exhaustion.
Cognitive Level: Evaluation
Nursing Process: Planning
Client Need: Psychosocial Integrity

26. **A nurse is working in an acute inpatient psychiatric unit. A coworker makes a disparaging remark about a client admitted with a blood alcohol level of 0.36 g/dL. In what way should the nurse respond?**
    a. Express immediately that the comment is inappropriate.
    b. Rephrase the remark to include the coworker.
    c. Encourage the coworker to take some time off from work.
    d. Assume the coworker is just relieving stress.

Grade: 0
User Responses: d.Assume the coworker is just relieving stress.
Feedback: a.Rationale: It is important for the nurse to immediately address the inappropriate comment. Substance abuse is a disease, not a flaw. It is unprofessional to assume that the inappropriate behavior is the result of stress. It is not the nurse's role to encourage the coworker to take time off. Rephrasing the remark to include the coworker is inappropriate.
Cognitive Level: Evaluation
Nursing Process: Implementation
Client Need: Psychosocial Integrity

27. **A client diagnosed with delirium tremens is confused and responding to tactile hallucinations. The nursing student assigned to the client runs out of the room and states, "That client is scaring me! I don' t know how to help him." What would be the most appropriate action by the nurse?**
    a. Explain the client's condition and stress that safety is a priority.
    b. Explain that clients who are confused and hallucinating are harmless.
    c. Encourage the nursing student to wear earplugs and stay out of arm's reach.
    d. Set strict limits on how often the client can be left unattended.

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Grade: 0
User Responses: d.Set strict limits on how often the client can be left unattended.
Feedback: a.Rationale: It is important to explain to the nursing student that confusion and hallucinations are symptoms of delirium tremens. It should be stressed that the client's safety is a top priority. Telling the nursing student that the client is harmless minimizes the concerns. Encouraging the nursing student to wear earplugs and sit far away from the client will jeopardize the client's safety. The client should not be left unattended, but the nursing student needs to understand the safety implications.
Cognitive Level: Evaluation
Nursing Process: Implementation
Client Need: Psychosocial Integrity

Chapter 15 Pre Test

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Activity Name: Chapter 15 Pre Test

1. b. Suicidal ideation
2. a. Psychiatric treatment is hindered if clients are under the influence of drugs or alcohol.
3. d. Agreeing with the client's reasons for using alcohol
4. c. Information about flashbacks
5. a. Amphetamine
6. c. Tremulousness, hallucinations, delirium tremens
7. b. The client has been sober for 12 days, states she is working on staying clean one day at a time, and has made arrangements to return to work part-time in 2 weeks.
8. a. "Al-Anon would be a good group for you to attend."
9. a. Assess the client's intent and follow-up behaviors for the surgeries.
10. c. Avoid the ingestion of any products that contain alcohol.
11. d. Al-Anon
12. b. Synaptic treatment
13. a. Disturbed thought processes related to the physiologic alterations of neurologic functioning.
14. c. Contemplation
15. d. Memory loss
16. a. Relapse
17. c. Counseling
18. b. "Relapse is always a threat. You need to consider making changes to your lifestyle if you want to stay clean."
19. a. Nausea and vomiting, sweating, anxiety, and coarse tremors
20. b. One-to-one supervision
21. b. Establish an airway.
22. d. Rationalization
23. b. Dependence involves impaired control of drug use, development of tolerance, and withdrawal symptoms occurring when intake is reduced or stopped.
24. a. She has developed tolerance.
25. c. Discuss her concerns with clinical supervisor.
26. a. Express immediately that the comment is inappropriate.
27. a. Explain the client's condition and stress that safety is a priority.