

Smith,Crystal

Submitted: 3/21/2011 12:53: Grade: 14.8%  43 PM

Attempt Number: 1/3

Questions Attempted: 27/27

1. **Each year two sisters fly to their hometown to meet at their mother's gravesite on the anniversary of her death. They are exhibiting:**
- a. Dysfunctional grieving.
 - b. Normal grief.
 - c. Bereavement.
 - d. Anticipatory grief.

Grade: 0

User Responses: d.Anticipatory grief.

Feedback: a.Rationale: They are exhibiting normal grief; they have moved on with their lives. It is not dysfunctional grieving; there is nothing in the scenario to suggest that their grief has not come to the point of resolution. Bereavement is a state of loss that is transient. The sisters are not expressing anticipatory grief because their mother has already died.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Psychosocial Integrity

2. **The Oncology Unit established a "grief team." The staff members hope it will: Select all that apply.**
- a. Reduce compassion fatigue.
 - b. Support the client's denial of cancer until he/she is able to deal with it.
 - c. Help the client's family accept death.
 - d. Provide nurturing.
 - e. Prevent eventual dysfunction.

Grade: 0

User Responses: c.Help the client's family accept death.,d.Provide nurturing.

Feedback: a.Rationale:
Reduce compassion fatigue. Reducing compassion fatigue is one of the purposes of Brosche's "grief team."

Prevent eventual dysfunction. Preventing eventual dysfunction is one of the purposes of Brosche's "grief team."

Provide nurturing. Providing nurturing in health care providers is one of the purposes of Brosche's "grief team."

Help the client's family accept death. Helping the client's family accept death is not an intervention for the staff members' needs.

Support the client's denial of cancer until he/she is able to deal with it. Supporting the client's denial of cancer is not an intervention for the staff members' needs.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Psychosocial Integrity

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3. **When planning a client's treatment for dysfunctional grieving, which of the following interventions would be most supportive of a positive outcome?**

Select all that apply.

- a. Group therapy
- b. Cognitive-behavioral therapy
- c. Anxiolytics
- d. Grief team
- e. Competent relationships

Grade: 0

User Responses: d.Grief team,e.Competent relationships

Feedback:

a.Rationale:

Cognitive-behavioral therapy. Since treatment for dysfunctional grieving resembles treatment for depression, cognitive-behavioral therapy is appropriate.

Group therapy. Since treatment for dysfunctional grieving resembles treatment for depression, group therapy is appropriate.

Competent relationships. Since treatment for dysfunctional grieving resembles treatment for depression, competent relationships are appropriate.

Anxiolytics. Anxiolytics are not used to treat dysfunctional grieving.

Grief team. A grief team is an intervention for health care providers.

Cognitive Level: Analysis

Nursing Process: Assessment

Client Need: Psychosocial Integrity

4. **What priority instruction should the nurse include in the discharge teaching plan for a client who has been recently diagnosed with major depressive disorder? Teach the client:**

- a. Safe use of antidepressant medication and potential drug/food interactions.
- b. That activity helps decrease depression.
- c. Problem-solving for small daily problems.
- d. Assertiveness techniques.

Grade: 0

User Responses: d.Assertiveness techniques.

Feedback:

a.Rationale: Teaching the safe use of antidepressant medication and potential drug/food interactions deals with safety, which is the priority issue. Teaching that activity helps decrease depression, assertiveness techniques, and problem-solving for small daily problems are appropriate to address in client teaching, but are not safety issues.

Cognitive Level: Evaluation

Nursing Process: Evaluation

Client Need: Psychosocial Integrity

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5. **To prepare a client for the anesthetic portion of ECT, which explanations would be most accurate? Select all that apply.**

- a. The client may have food and fluids immediately upon awakening.
- b. The client will be artificially ventilated at one point during ECT.
- c. A long-acting anesthetic is administered intravenously.
- d. A skeletal muscle relaxant is administered to prevent injuries during the seizure.
- e. An atropine-like drug is given to decrease secretions.

Grade: 0

User Responses: d.A skeletal muscle relaxant is administered to prevent injuries during the seizure.,e.An atropine-like drug is given to decrease secretions.

Feedback: a.Rationale:
An atropine-like drug is given to decrease secretions. The client is given an atropine-like drug to decrease secretions.

A skeletal muscle relaxant is administered to prevent injuries during the seizure. The client is given a skeletal muscle relaxant to prevent injuries during the seizure.

You will be artificially ventilated at one point during ECT. The client is artificially ventilated at one point during ECT.

A long-acting anesthetic is administered intravenously. A short acting anesthetic is administered intravenously.

You may have food and fluids immediately upon awakening. The client may not have food and fluids until the gag reflex returns.
Cognitive Level: Evaluation
Nursing Process: Implementation
Client Need: Physiological Integrity and Safe, Effective Care Environment

6. **A client is placed on isocarboxazid (Marplan). The nurse should teach the client and family that headaches and elevated blood pressure may be caused by:**

- a. The intake of tyramine-rich agents.
- b. Anticholinergic effects.
- c. An infection.
- d. Hyperglycemia.

Grade: 0

User Responses: d.Hyperglycemia.

Feedback: a.Rationale: Marplan is a monoamine oxidase inhibitor (MAOI) and requires the use of a low-tyramine diet, restricting aged, preserved and fermented foods, many types of beans, and many packaged sauce and spice mixes. Hyperglycemia, infections, and anticholinergic effects may occur, but would not cause headaches and elevated blood pressure.
Cognitive Level: Analysis
Nursing Process: Implementation
Client Need: Physiological Integrity

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7. **To determine whether a client is currently experiencing suicidal ideation, the nurse should ask:**
- a. "You don't want to kill yourself, do you?"
 - b. "Are you thinking about killing yourself?"
 - c. "Have you ever thought about harming yourself?"
 - d. "You don't want to hurt yourself, do you?"

Grade: 0

User Responses: d. "You don't want to hurt yourself, do you?"

Feedback: a. Rationale: "Are you thinking about killing yourself?" asks the client directly about current suicidal ideation. It assesses for initial suicidal risk and the need for increased safety precautions. "Have you ever thought about harming yourself?" does not assess for current safety needs. The implied negative communication approach of "You don't want to hurt yourself, do you?" sets the client up to say "No." "You don't want to kill yourself, do you?" uses the specific language recommended for assessing suicidality, but sets the client up to say "No."

Cognitive Level: Evaluation

Nursing Process: Assessment

Client Need: Physiological Integrity

8. **A client with depression is being discharged from the hospital after being treated for a suicide attempt. In planning the discharge, the nurse's priority teaching would include:**
- a. Identification of signs and symptoms of depression reoccurrence.
 - b. Identification of community resources and support if suicidal thoughts reoccur.
 - c. Ways to decrease isolation and increase peer support.
 - d. Ways to express feelings directly and appropriately.

Grade: 0

User Responses: d. Ways to express feelings directly and appropriately.

Feedback: a. Rationale: Identification of community resources and support if suicidal thoughts reoccur is the priority teaching because it is a safety issue. The other teaching suggestions of identifying signs and symptoms of depression, decreasing isolation, increasing peer support, and expressing feelings are appropriate, but they are not the priority.

Cognitive Level: Analysis

Nursing Process: Planning

Client Need: Safe, Effective Care Environment

9. **Which interventions should the nurse plan to include in a client's plan of care to prevent suicide? Select all that apply.**
- a. Establish a no-suicide contract.
 - b. Remove dangerous objects from client's environment.
 - c. Assess suicidal intent every shift.
 - d. Encourage frequent client discussion of suicidal ideations.
 - e. Use an irregular schedule for client observation rounds.

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User Responses: d. Encourage frequent client discussion of suicidal ideations., e. Use an irregular schedule for client observation rounds.

Feedback: a. Rationale:
Remove dangerous objects from client's environment. Removing dangerous objects from client's environment is a safety strategy to prevent suicide from occurring.

Use an irregular schedule for client observation rounds. Using an irregular schedule for client observation rounds is a safety strategy to prevent suicide from occurring.

Assess suicidal intent every shift. Assessing suicidal intent every shift is a safety strategy to prevent suicide from occurring.

Establish a no-suicide contract. Establishing a no-suicide contract is a safety strategy to prevent suicide from occurring.

Encourage frequent client discussion of suicidal ideations. While direct questioning about suicidal intent will not cause a client to think of suicide, frequent client discussion of suicidal ideations is incorrect because it encourages inappropriate rumination on suicide..

Cognitive Level: Application

Nursing Process: Planning

Client Need: Psychosocial Integrity

10. **For a client who has poor self-esteem, which outcome would the nurse consider most appropriate?**

- a. Expressions of satisfaction with current life circumstances
- b. An internal state of optimism that is personally satisfying and life-enhancing
- c. Personal judgment of self-worth
- d. Ability to choose between two or more alternatives

Grade: 0

User Responses: d. Ability to choose between two or more alternatives

Feedback: a. Rationale: The client's personal judgment of self-worth is the most appropriate outcome. An internal state of optimism that is personally satisfying and life-enhancing deals with hope. Expressions of satisfaction with current life circumstances address quality of life. The ability to choose between two or more alternatives focuses on decision-making.

Cognitive Level: Application

Nursing Process: Planning

Client Need: Psychosocial Integrity

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11. Which intervention should the nurse plan to implement to decrease a client's negative view of self?
- a. • Client will verbalize positive aspects of self and increased feelings of self-worth.
 - b. Counteract negative self-view and increase self worth.
 - c. Set limits on time spent reviewing past failures.
 - d. Minimize negative self-view.

Grade: 0

User Responses: d.Minimize negative self-view.

Feedback: a.Rationale: Setting limits on time spent reviewing past failures is an intervention. "Client will verbalize positive aspects of self and increased feelings of self-worth" is a short-term goal. Minimizing negative self-view, counteracting negative self-view, and increasing self-worth are rationales.
Cognitive Level: Application
Nursing Process: Planning
Client Need: Psychosocial Integrity

12. On admission to the hospital, a client reports having a negative view of self. The nurse will implement interventions such as positive, matter-of-fact reinforcement in order to:
- a. Model ways to decrease depression.
 - b. Focus the nurse's attention on personal strengths.
 - c. Increase feelings of self-worth.
 - d. Convey a cheerful attitude.

Grade: 0

User Responses: d.Convey a cheerful attitude.

Feedback: a.Rationale: Sincere recognition of accomplishments promotes self-esteem. Increasing feelings of self-worth would be the priority because it deals directly with a negative view of self. Teaching ways to decrease depression does not necessarily address negative view of self. A cheerful attitude is not an effective intervention for clients with depressive symptoms. Focusing the nurse's attention on the client's personal strengths is not therapeutic unless it is shared with the client.
Cognitive Level: Application
Nursing Process: Planning
Client Need: Psychosocial Integrity

13. The nurse performing an intake assessment would include which of the following objective data in the assessment of a mood disordered client?
- a. Profound psychomotor agitation or retardation
 - b. Impaired concentration
 - c. Fatigue
 - d. Feelings of sadness

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Grade: 0

User Responses: d. Feelings of sadness

Feedback: a. Rationale: Profound psychomotor agitation and retardation are objective data to be included in the assessment. Feelings of sadness, fatigue, and impaired concentration are subjective data.
Cognitive Level: Evaluation
Nursing Process: Assessment
Client Need: Physiological Integrity

14. The nurse at the mental health agency in a multi-ethnic community knows that if an Asian client reports an "imbalance," it may be a culturally determined way of expressing:
- a. Headaches.
 - b. Nerves.
 - c. Anhedonia.
 - d. Depression.

Grade: 1

User Responses: d. Depression.

Feedback: a. Rationale: "Imbalance" is a word Asians may use for depression. "Nerves" and "headaches" are words used by other cultures to express depression. Anhedonia is not taking pleasure in activities a person used to enjoy.
Cognitive Level: Evaluation
Nursing Process: Assessment
Client Need: Psychosocial Integrity

15. When assessing a client for mood disorders, it is most important for the nurse to consider whether there is an underlying:
- a. Feeling of sadness.
 - b. Sense of worthlessness.
 - c. Endocrine disorder.
 - d. Sleep disorder.

Grade: 0

User Responses: d. Sleep disorder.

Feedback: a. Rationale: Endocrine disorders are medical conditions that may manifest as symptoms of a mood disorder. Objective data should be obtained to rule out these disorders before a definitive diagnosis of mood disorder is made. Feelings of worthlessness, feelings of sadness, and sleep disorders are all subjective symptoms of mood disorders.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Psychosocial Integrity and Physiological Integrity

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16. **Animal studies have demonstrated that:**

- a. Estrogen decelerates the biological clock.
- b. Alcohol decelerates the biological clock.
- c. Antimanic drugs accelerate the biological clock.
- d. Tricyclic antidepressants decelerate the biological clock.

Grade: 0

User Responses: d.Tricyclic antidepressants decelerate the biological clock.

Feedback: a.Rationale: Alcohol and antimanic drugs slow the biological clock. Estrogen and tricyclic antidepressants accelerate the biological clock.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Physiological Integrity

17. **The most accurate name for the self-sustained internal physiological cycle that occurs every 24 hours and controls body temperature, sleep, and appetite is:**

- a. Biological rhythms.
- b. Circadian rhythms.
- c. The biological clock.
- d. Diurnal variations.

Grade: 0

User Responses: d.Diurnal variations.

Feedback: a.Rationale: Within the broad category of biological rhythms, circadian rhythms regulate the cycles of body temperature, sleep and appetite. The biological clock is the central controlling mechanism. Diurnal variations refer to the day-night patterns of mood, rest, some hormone levels, and physical and brain activity.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Psychosocial Integrity

18. **The nurse knows that circadian rhythm dysfunction explains a number of mood disorder symptoms but would not apply to:**

- a. Hypersomnia.
- b. Insomnia.
- c. Variations in appetite.
- d. Delusions.

Grade: 1

User Responses: d.Delusions.

Feedback: a.Rationale: Delusions are not a mood disorder symptom; they are a psychotic disorder symptom. Insomnia, hypersomnia, and variations in appetite may be caused by circadian rhythm dysfunction.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Physiological Integrity

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19. **A nurse feels annoyed by a client's demanding behaviors and becomes angry when the client consistently exceeds established limits. The nurse should:**
- a. Discuss his/her feelings with the nurse manager.
 - b. Realize that s/he is the only nurse willing to work with this client.
 - c. Avoid working with this client.
 - d. Point out other colleagues' inappropriate responses to the client.

Grade: 0

User Responses: d.Point out other colleagues' inappropriate responses to the client.

Feedback: a.Rationale: The nurse should discuss his/her feelings with the nurse manager to gain insight and self-awareness; it may lead to behaviors that support a more therapeutic communication with the client. Pointing out other colleagues' inappropriate responses to the client is not therapeutic. Avoiding working with this client does not allow for a personal growth experience. It may be accurate that s/he is the only nurse willing to work with this client, but it does not increase therapeutic communication skills unless supervision is provided.

Cognitive Level: Synthesis

Nursing Process: Implementation

Client Need: Psychosocial Integrity

20. **Which actions should the nurse take to prevent maladaptive dependence in the nurse-client relationship? Select all that apply.**
- a. Remind the client that social contact will not be allowed.
 - b. Do not discuss personal feelings about a client with a supervisor or instructor.
 - c. Emphasize the short-term nature of the relationship.
 - d. Do not give hope to the client that the nurse-patient relationship can continue after discharge.
 - e. Kindly refuse requests for a personal address or phone number.

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Grade: 0

User Responses: d.Do not give hope to the client that the nurse-patient relationship can continue after discharge.,e.Kindly refuse requests for a personal address or phone number.

Feedback: a.Rationale: Emphasize the short-term nature of the relationship. Emphasizing the short-term nature of the relationship helps to prevent maladaptive dependence.

Kindly refuse requests for a personal address or phone number. Kindly refusing requests for a personal address or phone number helps to prevent maladaptive dependence.

Remind the client that social contact will not be allowed. Reminding the client that social contact will not be allowed helps to prevent maladaptive dependence.

Do not give hope to the client that the nurse-patient relationship can continue after discharge. Not giving hope to the client that the nurse-patient relationship can continue after discharge helps to prevent maladaptive dependence.

Do not discuss personal feelings about a client with a supervisor or instructor. It is important to discuss feelings about a client with a supervisor or instructor who may offer suggestions for the specific situation.

Cognitive Level: Evaluation

Nursing Process: Implementation

Client Need: Psychosocial Integrity and Safe, Effective Care Environment

21. **The behavior of a client with mania is intrusive, e.g. taking meal trays into peers' rooms, opening mail and washing peers' clothes. The nurse should implement which intervention?**

- a. Enforce limits as punishment for not following the unit rules.
- b. Establish severe consequences for violating others' boundaries.
- c. Calmly and firmly establish limits on the client's intrusive behavior.
- d. Avoid the client until the manic episode is over.

Grade: 0

User Responses: d.Avoid the client until the manic episode is over.

Feedback: a.Rationale: The nurse must be aware that his/her behavior is a model for the out-of-control client. The nurse should use a calm, firm, and matter-of-fact style to communicate limits. Consequences for violating limits should be reasonable; establishing severe consequences or using limits as punishment may be a reflection of the nurse's control needs rather than the need to maintain the therapeutic nature of the milieu. Avoidance is not a therapeutic intervention; the nurse should consult the supervisor for alternatives to address the avoidant behavior and enhance his/her nursing skills.

Cognitive Level: Evaluation

Nursing Process: Implementation

Client Need: Safe, Effective Care Environment

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22. A 17-year-old client wants to go to the prom, but her parents state that "bad things happen in cars after the prom." The parents have discouraged peer involvement from grade school to present. According to psychoanalytic theorists, this may predispose the client to:

Select all that apply.

- a. Unresolved grief.
- b. Punitive superego.
- c. A love-hate relationship with the parents.
- d. Ambivalence.
- e. Strong ego development.

Grade: 0

User Responses: d.Ambivalence.,e.Strong ego development.

Feedback:

a.Rationale:

Ambivalence. Ambivalence may result from a desire to please the parents and a suppression of personal needs.

Punitive superego. A punitive superego may result from a desire to please the parents and a suppression of personal needs.

A love-hate relationship with the parents. A love-hate relationship with the parents may result from a desire to please the parents and a suppression of personal needs.

Unresolved grief. Unresolved grief may result from a desire to please the parents and a suppression of personal needs.

Strong ego development. This situation would result in weak ego development.

Cognitive Level: Analysis

Nursing Process: Assessment

Client Need: Psychosocial Integrity

23. A client states that he has no control over his life. He tells the nurse that his wife controls his friends and his boss limits his commissions. This is a cognitive theory called the theory of:

- a. Biologic factors.
- b. Unsatisfactory mother-infant relationship.
- c. Object loss.
- d. Learned helplessness.

Grade: 1

User Responses: d.Learned helplessness.

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Feedback:

a.Rationale: Learned helplessness is the only cognitive theory among the answer choices. The client has learned to be helpless by allowing others to control his life. An unsatisfactory mother-infant relationship, object loss theory, and biologic factors are not part of cognitive theory.
Cognitive Level: Synthesis
Nursing Process: Assessment
Client Need: Psychosocial Integrity

24. **A primary care nurse asks why medications are used so often in treating depression. A mental health nursing colleague familiar with biochemical theories of the etiology of mental illness, states that clients with depression tend to be deficient in:**
- a. Acetylcholine.
 - b. Monoamine neurotransmitters.
 - c. Melatonin.
 - d. Adrenaline.

Grade:

0

User Responses:

d.Adrenaline.

Feedback:

a.Rationale: According to biochemical theory, monoamine neurotransmitters, norepinephrine, serotonin, epinephrine, and dopamine may be deficient in clients with depression. Biochemical theory does not indicate that acetylcholine, melatonin, or adrenaline are deficient.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Psychosocial Integrity

25. **The nurse would expect the client in the depressive phase of bipolar disorder to have:**
- a. Grandiosity.
 - b. Flight of ideas.
 - c. Euphoria or irritability.
 - d. Anergia.

Grade:

1

User Responses:

d.Anergia.

Feedback:

a.Rationale: During the depressive phase, a client may have anergia, or lack of energy. Grandiosity, flight of ideas, and euphoria or irritability are all symptoms of the manic phase of bipolar disorder.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Physiological Integrity

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26. As they discuss a “mental health power of attorney,” the nurse and the client who has bipolar disorder will consider when hospitalization may be needed. The major difference between hypomania and mania is that in hypomania the client:
- a. Does not require hospitalization.
 - b. Behavior is excessive.
 - c. Has psychotic features.
 - d. Is more extreme.

Grade: 0

User Responses: d. Is more extreme.

Feedback: a. Rationale: Hypomania does not require hospitalization because it does not markedly impair functioning. In mania, the client may express psychotic symptoms. Behavior is excessive and more extreme in mania.
Cognitive Level: Analysis
Nursing Process: Analysis
Client Need: Psychosocial Integrity

27. To obtain information needed to support a diagnosis of major depressive disorder the nurse will ask, “Within a two-week period, have you ever had:
- a. Feelings of worthlessness or excessive or inappropriate guilt every day?”
 - b. Distractibility every day?”
 - c. A decreased need for sleep every day?”
 - d. Increase in goal directed activity or psychomotor agitation every day?”

Grade: 0

User Responses: d. Increase in goal directed activity or psychomotor agitation every day?”

Feedback: a. Rationale: Feelings of worthlessness or excessive or inappropriate guilt every day are symptoms of major depressive disorder. A decreased need for sleep, distractibility, and an increase in goal-directed activity or psychomotor agitation are symptoms of bipolar disorder.
Cognitive Level: Evaluation
Nursing Process: Assessment
Client Need: Physiological Integrity and Psychosocial Integrity

Activity Name: Chapter 17 Pre Test

1. b. Normal grief.
2. a. Reduce compassion fatigue. and e.Prevent eventual dysfunction. and d.Provide nurturing.
3. b. Cognitive-behavioral therapy and a.Group therapy and e.Competent relationships
4. a. Safe use of antidepressant medication and potential drug/food interactions.
5. e. An atropine-like drug is given to decrease secretions. and d.A skeletal muscle relaxant is administered to prevent injuries during the seizure. and b.The client will be artificially ventilated at one point during ECT.
6. a. The intake of tyramine-rich agents.
7. b. "Are you thinking about killing yourself?"
8. b. Identification of community resources and support if suicidal thoughts reoccur.
9. b. Remove dangerous objects from client's environment. and e.Use an irregular schedule for client observation rounds. and c.Assess suicidal intent every shift. and a.Establish a no-suicide contract.
10. c. Personal judgment of self-worth
11. c. Set limits on time spent reviewing past failures.
12. c. Increase feelings of self-worth.
13. a. Profound psychomotor agitation or retardation
14. d. Depression.
15. c. Endocrine disorder.
16. b. Alcohol decelerates the biological clock.
17. b. Circadian rhythms.
18. d. Delusions.
19. a. Discuss his/her feelings with the nurse manager.
20. c. Emphasize the short-term nature of the relationship. and e.Kindly refuse requests for a personal address or phone number. and a.Remind the client that social contact will not be allowed. and d.Do not give hope to the client that the nurse-patient relationship can continue after discharge.
21. c. Calmly and firmly establish limits on the client's intrusive behavior.
22. d. Ambivalence. and b.Punitive superego. and c.A love-hate relationship with the parents. and a.Unresolved grief.
23. d. Learned helplessness.
24. b. Monoamine neurotransmitters.
25. d. Anergia.
26. a. Does not require hospitalization.
27. a. Feelings of worthlessness or excessive or inappropriate guilt every day?"