

109 Questions and Rationale on Psychotic Disorders

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1. A psychotic client reports to the evening nurse that the day nurse put something suspicious in his water with his medication. The nurse replies, "You're worried about your medication?" The nurse's communication is:

- A. an example of presenting reality.
- B. reinforcing the client's delusions.
- C. focusing on emotional content.**
- D. a nontherapeutic technique called mind reading.

Rationale: The nurse should help the client focus on the emotional content rather than delusional material. Presenting reality isn't helpful because it can lead to confrontation and disengagement. Agreeing with the client and supporting his beliefs are reinforcing delusions. Mind reading isn't therapeutic.

2. A client is admitted to the inpatient unit of the mental health center with a diagnosis of paranoid schizophrenia. He's shouting that the government of France is trying to assassinate him. Which of the following responses is most appropriate?

- A. "I think you're wrong. France is a friendly country and an ally of the United States. Their government wouldn't try to kill you."
- B. "I find it hard to believe that a foreign government or anyone else is trying to hurt you. You must feel frightened by this."**
- C. "You're wrong. Nobody is trying to kill you."
- D. "A foreign government is trying to kill you? Please tell me more about it."

Rationale: Responses should focus on reality while acknowledging the client's feelings. Arguing with the client or denying his belief isn't therapeutic. Arguing can also inhibit development of a trusting relationship. Continuing to talk about delusions may aggravate the psychosis. Asking the client if a foreign government is trying to kill him may increase his anxiety level and can reinforce his delusions.

3. Propranolol (Inderal) is used in the mental health setting to manage which of the following conditions?

- A. Antipsychotic-induced akathisia and anxiety**
- B. The manic phase of bipolar illness as a mood stabilizer
- C. Delusions for clients suffering from schizophrenia
- D. Obsessive-compulsive disorder (OCD) to reduce ritualistic behavior

Rationale: Propranolol is a potent beta-adrenergic blocker and produces a sedating effect; therefore, it's used to treat antipsychotic induced akathisia and anxiety. Lithium (Lithobid) is used to stabilize clients with bipolar illness. Antipsychotics are used to treat delusions. Some antidepressants have been effective in treating OCD.

4. A client with borderline personality disorder becomes angry when he is told that today's psychotherapy session with the nurse will be delayed 30 minutes because of an emergency. When the session finally begins, the client expresses anger. Which response by the nurse would be most helpful in dealing with the client's anger?

- A. "If it had been your emergency, I would have made the other client wait."
- B. "I know it's frustrating to wait. I'm sorry this happened."
- C. "You had to wait. Can we talk about how this is making you feel right now?"**
- D. "I really care about you and I'll never let this happen again."

Rationale: This response may diffuse the client's anger by helping to maintain a therapeutic relationship and addressing the client's feelings. Option A wouldn't address the client's anger. Option B is incorrect because the client with a borderline personality disorder blames others for things that happen, so apologizing reinforces the client's misconceptions. The nurse can't promise that a delay will never occur again, as in option D, because such matters are outside the nurse's control.

5. How soon after chlorpromazine (Thorazine) administration should the nurse expect to see a client's delusional thoughts and hallucinations eliminated

- A. Several minutes
- B. Several hours
- C. Several days
- D. Several weeks**

Rationale: Although most phenothiazines produce some effects within minutes to hours, their antipsychotic effects may take several weeks to appear.

6. A client receiving haloperidol (Haldol) complains of a stiff jaw and difficulty swallowing. The nurse's first action is to:

- A. reassure the client and administer as needed lorazepam (Ativan) I.M.
- B. administer as needed dose of benztropine (Cogentin) I.M. as ordered.**
- C. administer as needed dose of benztropine (Cogentin) by mouth as ordered.
- D. administer as needed dose of haloperidol (Haldol) by mouth.

Rationale: The client is most likely suffering from muscle rigidity due to haloperidol. I.M. benztropine should be administered to prevent asphyxia or aspiration. Lorazepam treats anxiety, not extrapyramidal effects. Another dose of haloperidol would increase the severity of the reaction.

7. A client with a diagnosis of paranoid schizophrenia comments to the nurse, "How do I know what is really in those pills?" Which of the following is the best response?

- A. Say, "You know it's your medicine."
- B. Allow him to open the individual wrappers of the medication.**
- C. Say, "Don't worry about what is in the pills. It's what is ordered."
- D. Ignore the comment because it's probably a joke.

Rationale: Option B is correct because allowing a paranoid client to open his medication can help reduce suspiciousness. Option A is incorrect because the client doesn't know that it's his medication and he's obviously suspicious. Telling the client not to worry or ignoring the comment isn't supportive and doesn't offer reassurance.

8. The nurse is caring for a client with schizophrenia who experiences auditory hallucinations. The client appears to be listening to someone who isn't visible. He gestures, shouts angrily, and stops shouting in mid-sentence. Which nursing intervention is the most appropriate?

- A. Approach the client and touch him to get his attention.
- B. Encourage the client to go to his room where he'll experience fewer distractions.
- C. Acknowledge that the client is hearing voices but make it clear that the nurse doesn't hear these voices.**
- D. Ask the client to describe what the voices are saying.

Rationale: By acknowledging that the client hears voices, the nurse conveys acceptance of the client. By letting the client know that the nurse doesn't hear the voices, the nurse avoids reinforcing the hallucination. The nurse shouldn't touch the client with schizophrenia without advance warning. The hallucinating client may believe that the touch is a threat or act of aggression and respond violently. Being alone in his room encourages the client to withdraw and may promote more hallucinations. The nurse should provide an activity to distract the client. By asking the client what the voices are saying, the nurse is reinforcing the hallucination. The nurse should focus on the client's feelings, rather than the content of the hallucination.

9. Yesterday, a client with schizophrenia began treatment with haloperidol (Haldol). Today, the nurse notices that the client is holding his head to one side and complaining of neck and jaw spasms. What should the nurse do?

- A. Assume that the client is posturing.
- B. Tell the client to lie down and relax.
- C. Evaluate the client for adverse reactions to haloperidol.**
- D. Put the client on the list for the physician to see tomorrow

Rationale: An antipsychotic agent, such as haloperidol, can cause muscle spasms in the neck, face, tongue, back, and sometimes legs as well as torticollis (twisted neck position). The nurse should be aware of these adverse reactions and assess for related reactions promptly. Although posturing may occur in clients with schizophrenia, it isn't the same as neck and jaw spasms. Having the client relax can reduce tension-induced muscle stiffness but not drug-induced muscle spasms. When a client develops a new sign or symptom, the nurse should consider an adverse drug reaction as the possible cause and obtain treatment immediately, rather than have the client wait.

10. A client with paranoid schizophrenia has been experiencing auditory hallucinations for many years. One approach that has proven to be effective for hallucinating clients is to:

- A. take an as-needed dose of psychotropic medication whenever they hear voices.
- B. practice saying "Go away" or "Stop" when they hear voices.**
- C. sing loudly to drown out the voices and provide a distraction.
- D. go to their room until the voices go away.

Rationale: Researchers have found that some clients can learn to control bothersome hallucinations by telling the voices to go away or stop. Taking an as needed dose of psychotropic medication whenever the voices arise may lead to overmedication and put the client at risk for adverse effects. Because the voices aren't likely to go away permanently, the client must learn to deal with the hallucinations without relying on drugs. Although distraction is helpful, singing loudly may upset other clients and would be socially unacceptable after the client is discharged. Hallucinations are most bothersome in a quiet environment when the client is alone, so sending the client to his room would increase, rather than decrease, the hallucinations.

11. A client with catatonic schizophrenia is mute, can't perform activities of daily living, and stares out the window for hours. What is the nurse's first priority?

- A. Assist the client with feeding.**
- B. Assist the client with showering.
- C. Reassure the client about safety.
- D. Encourage socialization with peers.

Rationale: According to Maslow's hierarchy of needs, the need for food is among the most important. Other needs, in order of decreasing importance, include hygiene, safety, and a sense of belonging.

12. A client tells the nurse that the television newscaster is sending a secret message to her. The nurse suspects the client is experiencing:

- A. a delusion.
- B. flight of ideas.
- C. ideas of reference.**
- D. a hallucination.

Rationale: Ideas of reference refers to the mistaken belief that neutral stimuli have special meaning to the individual such as the television newscaster sending a message directly to the individual. A delusion is a false belief. Flight of ideas is a speech pattern in which the client skips from one unrelated subject to another. A hallucination is a sensory perception, such as hearing voices and seeing objects, that only the client experiences.

13. The nurse knows that the physician has ordered the liquid form of the drug chlorpromazine (Thorazine) rather than the tablet form because the liquid:

- A. has a more predictable onset of action.**
- B. produces fewer anticholinergic effects.
- C. produces fewer drug interactions.

D. has a longer duration of action.

Rationale: A liquid phenothiazine preparation will produce effects in 2 to 4 hours. The onset with tablets is unpredictable.

14. A client who has been hospitalized with disorganized type schizophrenia for 8 years can't complete activities of daily living (ADLs) without staff direction and assistance. The nurse formulates a nursing diagnosis of Self-care deficient: Dressing/grooming related to inability to function without assistance. What is an appropriate goal for this client?

- A. "Client will be able to complete ADLs independently within 1 month."
- B. "Client will be able to complete ADLs with only verbal encouragement within 1 month."
- C. "Client will be able to complete ADLs with assistance in organizing grooming items and clothing within 1 month."**
- D. "Client will be able to complete ADLs with complete assistance within 1 month."

Rationale: The client's disorganized personality and history of hospitalization have affected the ability to perform self-care activities. Interventions should be directed at helping the client complete ADLs with the assistance of staff members, who can provide needed structure by helping the client select grooming items and clothing. This goal promotes realistic independence. As the client improves and achieves the established goal, the nurse can set new goals that focus on the client completing ADLs with only verbal encouragement and, ultimately, completing them independently. The client's condition doesn't indicate a need for complete assistance, which would only foster dependence.

15. The nurse is planning care for a client admitted to the psychiatric unit with a diagnosis of paranoid schizophrenia. Which nursing diagnosis should receive the highest priority?

- A. Risk for violence toward self or others**
- B. Imbalanced nutrition: Less than body requirements
- C. Ineffective family coping
- D. Impaired verbal communication

Rationale: Because of such factors as suspiciousness, anxiety, and hallucinations, the client with paranoid schizophrenia is at risk for violence toward himself or others. The other options are also appropriate nursing diagnoses but should be addressed after the safety of the client and those around him is established.

16. The nurse is preparing for the discharge of a client who has been hospitalized for paranoid schizophrenia. The client's husband expresses concern over whether his wife will continue to take her daily prescribed medication. The nurse should inform him that:

- A. his concern is valid but his wife is an adult and has the right to make her own decisions.

- B. he can easily mix the medication in his wife's food if she stops taking it.
- C. his wife can be given a long-acting medication that is administered every 1 to 4 weeks.**
- D. his wife knows she must take her medication as prescribed to avoid future hospitalizations.

Rationale: Long-acting psychotropic drugs can be administered by depot injection every 1 to 4 weeks. These agents are useful for noncompliant clients because the client receives the injection at the outpatient clinic. A client has the right to refuse medication, but this issue isn't the focus of discussion at this time. Medication should never be hidden in food or drink to trick the client into taking it; besides destroying the client's trust, doing so would place the client at risk for overmedication or undermedication because the amount administered is hard to determine. Assuming the client knows she must take the medication to avoid future hospitalizations would be unrealistic.

17. Benztropine (Cogentin) is used to treat the extrapyramidal effects induced by antipsychotics. This drug exerts its effect by:

- A. decreasing the anxiety causing muscle rigidity.
- B. blocking the cholinergic activity in the central nervous system (CNS).**
- C. increasing the level of acetylcholine in the CNS.
- D. increasing norepinephrine in the CNS.

Rationale: Option B is the action of Cogentin. Anxiety doesn't cause extrapyramidal effects. Overactivity of acetylcholine and lower levels of dopamine are the causes of extrapyramidal effects. Benztropine doesn't increase norepinephrine in the CNS.

18. A client is admitted to the inpatient unit of the mental health center with a diagnosis of paranoid schizophrenia. He's shouting that the government of France is trying to assassinate him. Which of the following responses is most appropriate?

- A. "I think you're wrong. France is a friendly country and an ally of the United States. Their government wouldn't try to kill you."
- B. "I find it hard to believe that a foreign government or anyone else is trying to hurt you. You must feel frightened by this."**
- C. "You're wrong. Nobody is trying to kill you."
- D. "A foreign government is trying to kill you? Please tell me more about it."

Rationale: Responses should focus on reality while acknowledging the client's feelings. Arguing with the client or denying his belief isn't therapeutic. Arguing can also inhibit development of a trusting relationship. Continuing to talk about delusions may aggravate the psychosis. Asking the client if a foreign government is trying to kill him may increase his anxiety level and can reinforce his delusions.

19. A dopamine receptor agonist such as bromocriptine (Parlodel) relieves muscle rigidity caused by antipsychotic medication by:

- A. blocking dopamine receptors in the central nervous system (CNS).

- B. blocking acetylcholine in the CNS.
- C. activating norepinephrine in the CNS.
- D. activating dopamine receptors in the CNS.**

Rationale: Extrapyramidal effects and the muscle rigidity induced by antipsychotic medications are caused by a low level of dopamine. Dopamine receptor agonists stimulate dopamine receptors and thereby reduce rigidity. They don't affect norepinephrine or acetylcholine.

20. Most antipsychotic medications exert which of following effects on the central nervous system (CNS)?

- A. Stimulate the CNS by blocking postsynaptic dopamine, norepinephrine, and serotonin receptors.
- B. Sedate the CNS by stimulating serotonin at the synaptic cleft.
- C. Depress the CNS by blocking the postsynaptic transmission of dopamine, serotonin, and norepinephrine.**
- D. Depress the CNS by stimulating the release of acetylcholine.

Rationale: The exact mechanism of antipsychotic medication action is unknown, but appear to depress the CNS by blocking the transmission of three neurotransmitters: dopamine, serotonin, and norepinephrine. They don't sedate the CNS by stimulating serotonin, and they don't stimulate neurotransmitter action or acetylcholine release.

21. A client is admitted to the psychiatric unit of a local hospital with chronic undifferentiated schizophrenia. During the next several days, the client is seen laughing, yelling, and talking to herself. This behavior is characteristic of:

- A. delusion.
- B. looseness of association.
- C. illusion.
- D. hallucination.**

Rationale: Auditory hallucination, in which one hears voices when no external stimuli exist, is common in schizophrenic clients. Such behaviors as laughing, yelling, and talking to oneself suggest such a hallucination. Delusions, also common in schizophrenia, are false beliefs or ideas that arise without external stimuli. Clients with schizophrenia may exhibit looseness of association, a pattern of thinking and communicating in which ideas aren't clearly linked to one another. Illusion is a less severe perceptual disturbance in which the client misinterprets actual external stimuli. Illusions are rarely associated with schizophrenia.

22. Which of the following medications would the nurse expect the physician to order to reverse a dystonic reaction?

- A. prochlorperazine (Compazine)
- B. diphenhydramine (Benadryl)**
- C. haloperidol (Haldol)

D. midazolam (Versed)

Rationale: Diphenhydramine, 25 to 50 mg I.M. or I.V., would quickly reverse this condition. Prochlorperazine and haloperidol are both capable of causing dystonia, not reversing it. Midazolam would make this client drowsy.

23. A schizophrenic client states, "I hear the voice of King Tut." Which response by the nurse would be most therapeutic?

- A. **"I don't hear the voice, but I know you hear what sounds like a voice."**
- B. "You shouldn't focus on that voice."
- C. "Don't worry about the voice as long as it doesn't belong to anyone real."
- D. "King Tut has been dead for years."

Rationale: This response states reality about the client's hallucination. The other options are judgmental, flippant, or dismissive.

24. A psychotic client reports to the evening nurse that the day nurse put something suspicious in his water with his medication. The nurse replies, "You're worried about your medication?" The nurse's communication is:

- A. an example of presenting reality.
- B. reinforcing the client's delusions.
- C. **focusing on emotional content.**
- D. a nontherapeutic technique called mind reading.

Rationale: The nurse should help the client focus on the emotional content rather than delusional material. Presenting reality isn't helpful because it can lead to confrontation and disengagement. Agreeing with the client and supporting his beliefs are reinforcing delusions. Mind reading isn't therapeutic.

25. The nurse is caring for a client with schizophrenia who experiences auditory hallucinations. The client appears to be listening to someone who isn't visible. He gestures, shouts angrily, and stops shouting in mid-sentence. Which nursing intervention is the most appropriate?

- A. Approach the client and touch him to get his attention.
- B. Encourage the client to go to his room where he'll experience fewer distractions.
- C. **Acknowledge that the client is hearing voices but make it clear that the nurse doesn't hear these voices.**
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Rationale: By acknowledging that the client hears voices, the nurse conveys acceptance of the client. By letting the client know that the nurse doesn't hear the voices, the nurse avoids reinforcing the hallucination. The nurse shouldn't touch the client with schizophrenia without advance warning. The hallucinating client may believe that the touch is a threat or act of aggression and respond violently. Being alone in his room encourages the client to withdraw and may promote more hallucinations. The nurse

should provide an activity to distract the client. By asking the client what the voices are saying, the nurse is reinforcing the hallucination. The nurse should focus on the client's feelings, rather than the content of the hallucination.

26. A client has been receiving chlorpromazine (Thorazine), an antipsychotic, to treat his psychosis. Which findings should alert the nurse that the client is experiencing pseudoparkinsonism?

- A. Restlessness, difficulty sitting still, and pacing
- B. Involuntary rolling of the eyes
- C. Tremors, shuffling gait, and masklike face**
- D. Extremity and neck spasms, facial grimacing, and jerky movements

Rationale: Pseudoparkinsonism may appear 1 to 5 days after starting an antipsychotic and may also include drooling, rigidity, and "pill rolling." Akathisia may occur several weeks after starting antipsychotic therapy and consists of restlessness, difficulty sitting still, and fidgeting. An oculogyric crisis is recognized by uncontrollable rolling back of the eyes and, along with dystonia, should be considered an emergency. Dystonia may occur minutes to hours after receiving an antipsychotic and may include extremity and neck spasms, jerky muscle movements, and facial grimacing.

27. For several years, a client with chronic schizophrenia has received 10 mg of fluphenazine hydrochloride (Prolixin) by mouth four times per day. Now the client has a temperature of 102° F (38.9° C), a heart rate of 120 beats/minute, a respiratory rate of 20 breaths/minute, and a blood pressure of 210/140 mm Hg. Because the client also is confused and incontinent, the nurse suspects malignant neuroleptic syndrome. What steps should the nurse take?

- A. Give the next dose of fluphenazine, call the physician, and monitor vital signs.
- B. Withhold the next dose of fluphenazine, call the physician, and monitor vital signs.**
- C. Give the next dose of fluphenazine and restrict the client to the room to decrease stimulation.
- D. Withhold the next dose of fluphenazine, administer an antipyretic agent, and increase the client's fluid intake.

Rationale: Malignant neuroleptic syndrome is a dangerous adverse effect of neuroleptic drugs such as fluphenazine. The nurse should withhold the next dose, notify the physician, and continue to monitor vital signs. Although an antipyretic agent may be used to reduce fever, increased fluid intake is contraindicated because it may increase the client's fluid volume further, raising blood pressure even higher.

28. A schizophrenic client with delusions tells the nurse, "There is a man wearing a red coat who's out to get me." The client exhibits increasing anxiety when focusing on the delusions. Which of the following would be the best response?

- A. "This subject seems to be troubling you. Let's walk to the activity room."**
- B. "Describe the man who's out to get you. What does he look like?"

- C. "There is no reason to be afraid of that man. This hospital is very secure."
- D. "There is no need to be concerned with a man who isn't even real."

Rationale: This remark distracts the client from the delusion by engaging the client in a less threatening or more comforting activity at the first sign of anxiety. The nurse should reinforce reality and discourage the false belief. The other options focus on the content of the delusion rather than the meaning, feeling, or intent that it provokes.

29. Important teaching for women in their childbearing years who are receiving antipsychotic medications includes which of the following?

- A. Occurrence of increased libido due to medication adverse effects
- B. Increased incidence of dysmenorrhea while taking the drug
- C. Continuing previous use of contraception during periods of amenorrhea**
- D. Instruction that amenorrhea is irreversible

Rationale: Women may experience amenorrhea, which is reversible, while taking antipsychotics. Amenorrhea doesn't indicate cessation of ovulation; therefore, the client can still become pregnant. The client should be instructed to continue contraceptive use even when experiencing amenorrhea. Dysmenorrhea isn't an adverse effect of antipsychotics, and libido generally decreases because of the depressant effect.

30. A client is admitted to a psychiatric facility with a diagnosis of chronic schizophrenia. The history indicates that the client has been taking neuroleptic medication for many years. Assessment reveals unusual movements of the tongue, neck, and arms. Which condition should the nurse suspect?

- A. Tardive dyskinesia**
- B. Dystonia
- C. Neuroleptic malignant syndrome
- D. Akathisia

Rationale: Unusual movements of the tongue, neck, and arms suggest tardive dyskinesia, an adverse reaction to neuroleptic medication. Dystonia is characterized by cramps and rigidity of the tongue, face, neck, and back muscles. Neuroleptic malignant syndrome causes rigidity, fever, hypertension, and diaphoresis. Akathisia causes restlessness, anxiety, and jitteriness.

31. What medication would probably be ordered for the acutely aggressive schizophrenic client?

- A. chlorpromazine (Thorazine)
- B. haloperidol (Haldol)
- C. lithium carbonate (Lithonate)
- D. amitriptyline (Elavil)

Rationale: Haloperidol administered I.M. or I.V. is the drug of choice for acute aggressive psychotic behavior. Chlorpromazine is also an antipsychotic drug; however, it

causes more pronounced sedation than haloperidol. Lithium carbonate is useful in bipolar or manic disorder, and amitriptyline is used for depression.

32. A client is admitted with a diagnosis of schizotypal personality disorder. Which signs would this client exhibit during social situations?

- A. Aggressive behavior
- B. Paranoid thoughts**
- C. Emotional affect
- D. Independence needs

Rationale: Clients with schizotypal personality disorder experience excessive social anxiety that can lead to paranoid thoughts. Aggressive behavior is uncommon, although these clients may experience agitation with anxiety. Their behavior is emotionally cold with a flattened affect, regardless of the situation. These clients demonstrate a reduced capacity for close or dependent relationships.

33. During the initial interview, a client with schizophrenia suddenly turns to the empty chair beside him and whispers, "Now just leave. I told you to stay home. There isn't enough work here for both of us!" What is the nurse's best initial response?

- A. "When people are under stress, they may see things or hear things that others don't. Is that what just happened?"**
- B. "I'm having a difficult time hearing you. Please look at me when you talk."
- C. "There is no one else in the room. What are you doing?"
- D. "Who are you talking to? Are you hallucinating?"

Rationale: This response makes the client feel that experiencing hallucinations is acceptable and promotes an open, therapeutic relationship. Directing the client to look at the nurse wouldn't address the obvious issue of the hallucination. Confrontational approaches, such as in options C and D, are likely to elicit an uninformative or negative response.

34. The definition of nihilistic delusions is:

- A. a false belief about the functioning of the body.
- B. belief that the body is deformed or defective in a specific way.
- C. false ideas about the self, others, or the world**
- D. the inability to carry out motor activities.

Rationale: Nihilistic delusions are false ideas about the self, others, or the world. Somatic delusions involve a false belief about the functioning of the body. Body dysmorphic disorder is characterized by a belief that the body is deformed or defective in a specific way. Apraxia is the inability to carry out motor activities.

35. A client who's taking antipsychotic medication develops a very high temperature, severe muscle rigidity, tachycardia, and rapid deterioration in mental status. The nurse suspects what complication of antipsychotic therapy?

- A. Agranulocytosis
- B. Extrapramidal effects
- C. Anticholinergic effects
- D. Neuroleptic malignant syndrome (NMS)**

Rationale: A rare but potentially fatal condition of antipsychotic medication is called NMS. It generally starts with an elevated temperature and severe extrapyramidal effects. Agranulocytosis is a blood disorder. Anticholinergic effects include blurred vision, drowsiness, and dry mouth. Symptoms of extrapyramidal effects include tremors, restlessness, muscle spasms, and pseudoparkinsonism.

36. The nurse formulates a nursing diagnosis of Impaired social interaction related to disorganized thinking for a client with schizotypal personality disorder. Based on this nursing diagnosis, which nursing intervention takes highest priority?

- A. Helping the client to participate in social interactions
- B. Establishing a one-on-one relationship with the client**
- C. Exploring the effects of the client's behavior on social interactions
- D. Developing a schedule for the client's participation in social interactions

Rationale: By establishing a one-on-one relationship, the nurse helps the client learn how to interact with people in new situations. The other options are appropriate but should take place only after the nurse-client relationship is established.

37. A client with schizophrenia hears a voice telling him he is evil and must die. The nurse understands that the client is experiencing:

- A. a delusion.
- B. flight of ideas.
- C. ideas of reference.
- D. a hallucination.**

Rationale: A hallucination is a sensory perception, such as hearing voices and seeing objects, that only the client experiences. A delusion is a false belief. Flight of ideas refers to a speech pattern in which the client skips from one unrelated subject to another. Ideas of reference refers to the mistaken belief that someone or something outside the client is controlling the client's ideas or behavior.

38. A client with delusional thinking shows a lack of interest in eating at meal times. She states that she is unworthy of eating and that her children will die if she eats. Which nursing action would be most appropriate for this client?

- A. Telling the client that she may become sick and die unless she eats
- B. Paying special attention to the client's rituals and emotions associated with meals
- C. Restricting the client's access to food except at specified meal and snack times**
- D. Encouraging the client to express her feelings at meal times

Rationale: Restricting access to food except at specified times prevents the client from eating when she feels anxious, guilty, or depressed; this, in turn, decreases the association between these emotions and food. Telling the client she may become sick or die may reinforce her behavior because illness or death may be her goal. Paying special attention to rituals and emotions associated with meals also would reinforce undesirable behavior. Encouraging the client to express feelings at meal times would increase the association between emotions and food; instead, the nurse should encourage her to express feelings at other times.

39. Which of the following groups of characteristics would the nurse expect to see in the client with schizophrenia?

- A. **Loose associations, grandiose delusions, and auditory hallucinations**
- B. Periods of hyperactivity and irritability alternating with depression
- C. Delusions of jealousy and persecution, paranoia, and mistrust
- D. Sadness, apathy, feelings of worthlessness, anorexia, and weight loss

Rationale: Loose associations, grandiose delusions, and auditory hallucinations are all characteristic of the classic schizophrenic client. These clients aren't able to care for their physical appearance. They frequently hear voices telling them to do something either to themselves or to others. Additionally, they verbally ramble from one topic to the next. Periods of hyperactivity and irritability alternating with depression are characteristic of bipolar or manic disease. Delusions of jealousy and persecution, paranoia, and mistrust are characteristics of paranoid disorders. Sadness, apathy, feelings of worthlessness, anorexia, and weight loss are characteristics of depression.

40. The nurse must administer a medication to reverse or prevent Parkinson-type symptoms in a client receiving an antipsychotic. The medication the client will likely receive is:

- A. **Benzotropine (Cogentin).**
- B. diphenhydramine (Benadryl).
- C. propranolol (Inderal).
- D. haloperidol (Haldol).

Rationale: Benzotropine, trihexyphenidyl, or amantadine are prescribed for a client with Parkinson-type symptoms. Diphenhydramine provides rapid relief for dystonia. Propranolol relieves akathisia. Haloperidol can cause Parkinson-type symptoms.

41. A client is receiving haloperidol (Haldol) to reduce psychotic symptoms. As he watches television with other clients, the nurse notes that he has trouble sitting still. He seems restless, constantly moving his hands and feet and changing position. When the nurse asks what is wrong, he says he feels jittery. How should the nurse manage this situation?

- A. Ask the client to sit still or leave the room because he is distracting the other clients.
- B. Ask the client if he is nervous or anxious about something.
- C. **Give an as needed dose of a prescribed anticholinergic agent to control akathisia.**

D. Administer an as needed dose of haloperidol to decrease agitation.

Rationale: Akathisia, characterized by restlessness, is a common but often overlooked adverse reaction to haloperidol and other antipsychotic agents; it may be confused with psychotic agitation. To control akathisia, the nurse should give an as needed dose of a prescribed anticholinergic agent. The client can't control the movements, so asking him to sit still would be pointless. Asking him to leave the room wouldn't address the underlying cause of the problem. Encouraging him to talk about the symptoms wouldn't stop them from occurring. Giving more antipsychotic medication would worsen akathisia.

42. A man is brought to the hospital by his wife, who states that for the past week her husband has refused all meals and accused her of trying to poison him. During the initial interview, the client's speech, only partly comprehensible, reveals that his thoughts are controlled by delusions that he is possessed by the devil. The physician diagnoses paranoid schizophrenia. Schizophrenia is best described as a disorder characterized by:

- A. disturbed relationships related to an inability to communicate and think clearly.**
- B. severe mood swings and periods of low to high activity.
- C. multiple personalities, one of which is more destructive than the others.
- D. auditory and tactile hallucinations.

Rationale: Schizophrenia is best described as one of a group of psychotic reactions characterized by disturbed relationships with others and an inability to communicate and think clearly. Schizophrenic thoughts, feelings, and behavior commonly are evidenced by withdrawal, fluctuating moods, disordered thinking, and regressive tendencies. Severe mood swings and periods of low to high activity are typical of bipolar disorder. Multiple personality, sometimes confused with schizophrenia, is a dissociative personality disorder, not a psychotic illness. Many schizophrenic clients have auditory hallucinations; tactile hallucinations are more common in organic or toxic disorders

43. A client has a history of chronic undifferentiated schizophrenia. Because she has a history of noncompliance with antipsychotic therapy, she'll receive fluphenazine decanoate (Prolixin Decanoate) injections every 4 weeks. Before discharge, what should the nurse include in her teaching plan?

- A. Asking the physician for droperidol (Inapsine) to control any extrapyramidal symptoms that occur
- B. Sitting up for a few minutes before standing to minimize orthostatic hypotension**
- C. Notifying the physician if her thoughts don't normalize within 1 week
- D. Expecting symptoms of tardive dyskinesia to occur and to be transient

Rationale: The nurse should teach the client how to manage common adverse reactions, such as orthostatic hypotension and anticholinergic effects. Antipsychotic effects of the drug may take several weeks to appear. Droperidol increases the risk of extrapyramidal effects when given in conjunction with phenothiazines such as fluphenazine. Tardive dyskinesia is a possible adverse reaction and should be reported immediately

44. A client with chronic schizophrenia who takes neuroleptic medication is admitted to

the psychiatric unit. Nursing assessment reveals rigidity, fever, hypertension, and diaphoresis. These findings suggest which life-threatening reaction:

- A. tardive dyskinesia.
- B. dystonia.
- C. neuroleptic malignant syndrome.**
- D. akathisia.

Rationale: The client's signs and symptoms suggest neuroleptic malignant syndrome, a life-threatening reaction to neuroleptic medication that requires immediate treatment. Tardive dyskinesia causes involuntary movements of the tongue, mouth, facial muscles, and arm and leg muscles. Dystonia is characterized by cramps and rigidity of the tongue, face, neck, and back muscles. Akathisia causes restlessness, anxiety, and jitteriness.

45. While looking out the window, a client with schizophrenia remarks, "That school across the street has creatures in it that are waiting for me." Which of the following terms best describes what the creatures represent?

- A. Anxiety attack
- B. Projection
- C. Hallucination
- D. Delusion

Rationale: A delusion is a false belief based on a misrepresentation of a real event or experience. Although anxiety can increase delusional responses, it isn't considered the primary symptom. Projection is falsely attributing to another person one's own unacceptable feelings. Hallucinations, which characterize most psychoses, are perceptual disorders of the five senses; the client may see, taste, feel, smell, or hear something in the absence of external stimulation

46. A client with schizophrenia tells the nurse, "My intestines are rotted from the worms chewing on them." This statement indicates a:

- A. delusion of persecution.
- B. delusion of grandeur.
- C. somatic delusion.**
- D. jealous delusion.

Rationale: Somatic delusions focus on bodily functions or systems and commonly include delusions about foul odor emissions, insect infestations, internal parasites, and misshapen parts. Delusions of persecution are morbid beliefs that one is being mistreated and harassed by unidentified enemies. Delusions of grandeur are gross exaggerations of one's importance, wealth, power, or talents. Jealous delusions are delusions that one's spouse or lover is unfaithful.

47. During the assessment stage, a client with schizophrenia leaves his arm in the air after the nurse has taken his blood pressure. His action shows evidence of:

- A. somatic delusions.
- B. waxy flexibility.**
- C. neologisms.
- D. nihilistic delusions.

Rationale: The correct answer is waxy flexibility, which is defined as retaining any position that the body has been placed in. Somatic delusions involve a false belief about the functioning of the body. Neologisms are invented meaningless words. Nihilistic delusions are false ideas about self, others, or the world.

48. A client with paranoid type schizophrenia becomes angry and tells the nurse to leave him alone. The nurse should

- A. tell him that she'll leave for now but will return soon.**
- B. ask him if it's okay if she sits quietly with him.
- C. ask him why he wants to be left alone.
- D. tell him that she won't let anything happen to him

Rationale: If the client tells the nurse to leave, the nurse should leave but let the client know that she'll return so that he doesn't feel abandoned. Not heeding the client's request can agitate him further. Also, challenging the client isn't therapeutic and may increase his anger. False reassurance isn't warranted in this situation

49. Nursing care for a client with schizophrenia must be based on valid psychiatric and nursing theories. The nurse's interpersonal communication with the client and specific nursing interventions must be:

- A. clearly identified with boundaries and specifically defined roles.
- B. warm and nonthreatening.
- C. centered on clearly defined limits and expression of empathy.
- D. flexible enough for the nurse to adjust the plan of care as the situation warrants.**

Rationale: A flexible plan of care is needed for any client who behaves in a suspicious, withdrawn, or regressed manner or who has a thought disorder. Because such a client communicates at different levels and is in control of himself at various times, the nurse must be able to adjust nursing care as the situation warrants. The nurse's role should be clear; however, the boundaries or limits of this role should be flexible enough to meet client needs. Because a client with schizophrenia fears closeness and affection, a warm approach may be too threatening. Expressing empathy is important, but centering interventions on clearly defined limits is impossible because the client's situation may change without warning.

50. When discharging a client after treatment for a dystonic reaction, the emergency department nurse must ensure that the client understands which of the following?

- A. Results of treatment are rapid and dramatic but may not last.
- B. Although uncomfortable, this reaction isn't serious.
- C. The client shouldn't buy drugs on the street.

D. The client must take benztropine (Cogentin) as prescribed to prevent a return of symptoms.

Rationale: An oral anticholinergic agent such as benztropine (Cogentin) is commonly prescribed to control and prevent the return of symptoms. Dystonic reactions are typically acute and reversible. Dystonic reactions can be life-threatening when airway patency is compromised. Lecturing the client about buying drugs on the street isn't appropriate

51. The nurse is caring for a client with schizophrenia. Which of the following outcomes is the least desirable?

- A. The client spends more time by himself.**
- B. The client doesn't engage in delusional thinking.
- C. The client doesn't harm himself or others.
- D. The client demonstrates the ability to meet his own self-care needs.

Rationale: The client with schizophrenia is commonly socially isolated and withdrawn; therefore, having the client spend more time by himself wouldn't be a desirable outcome. Rather, a desirable outcome would specify that the client spend more time with other clients and staff on the unit. Delusions are false personal beliefs. Reducing or eliminating delusional thinking using talking therapy and antipsychotic medications would be a desirable outcome. Protecting the client and others from harm is a desirable client outcome achieved by close observation, removing any dangerous objects, and administering medications. Because the client with schizophrenia may have difficulty meeting his or her own self-care needs, fostering the ability to perform self-care independently is a desirable client outcome.

52. The nurse formulates a nursing diagnosis of Impaired verbal communication for a client with schizotypal personality disorder. Based on this nursing diagnosis, which nursing intervention is most appropriate?

- A. Helping the client to participate in social interactions
- B. Establishing a one-on-one relationship with the client**
- C. Establishing alternative forms of communication
- D. Allowing the client to decide when he wants to participate in verbal communication with the nurse

Rationale: By establishing a one-on-one relationship, the nurse helps the client learn how to interact with people in new situations. The other options are appropriate but should take place only after the nurse-client relationship is established.

53. Since admission 4 days ago, a client has refused to take a shower, stating, "There are poison crystals hidden in the showerhead. They'll kill me if I take a shower." Which nursing action is most appropriate?

- A. Dismantling the showerhead and showing the client that there is nothing in it
- B. Explaining that other clients are complaining about the client's body odor
- C. Asking a security officer to assist in giving the client a shower
- D. Accepting these fears and allowing the client to take a sponge bath**

Rationale: By acknowledging the client's fears, the nurse can arrange to meet the client's hygiene needs in another way. Because these fears are real to the client, providing a demonstration of reality (as in option A) wouldn't be effective at this time. Options B and C would violate the client's rights by shaming or embarrassing the client.

54. Drug therapy with thioridazine (Mellaril) shouldn't exceed a daily dose of 800 mg to prevent which adverse reaction?

- A. Hypertension
- B. Respiratory arrest
- C. Tourette syndrome
- D. Retinal pigmentation**

Rationale: Retinal pigmentation may occur if the thioridazine dosage exceeds 800 mg per day. The other options don't occur as a result of exceeding this dose.

55. A client with paranoid personality disorder is admitted to a psychiatric facility. Which remark by the nurse would best establish rapport and encourage the client to confide in the nurse?

- A. "I get upset once in a while, too."**
- B. "I know just how you feel. I'd feel the same way in your situation."
- C. "I worry, too, when I think people are talking about me."
- D. "At times, it's normal not to trust anyone."

Rationale: Sharing a benign, nonthreatening, personal fact or feeling helps the nurse establish rapport and encourages the client to confide in the nurse. The nurse can't know how the client feels. Telling the client otherwise, as in option B, would justify the suspicions of a paranoid client; furthermore, the client relies on the nurse to interpret reality. Option C is incorrect because it focuses on the nurse's feelings, not the client's. Option D wouldn't help establish rapport or encourage the client to confide in the nurse.

56. How soon after chlorpromazine (Thorazine) administration should the nurse expect to see a client's delusional thoughts and hallucinations eliminated?

- A. Several minutes
- B. Several hours
- C. Several days
- D. Several weeks**

Rationale: Although most phenothiazines produce some effects within minutes to hours, their antipsychotic effects may take several weeks to appear.

57. A client is about to be discharged with a prescription for the antipsychotic agent haloperidol (Haldol), 10 mg by mouth twice per day. During a discharge teaching session, the nurse should provide which instruction to the client?

- A. Take the medication 1 hour before a meal.
- B. Decrease the dosage if signs of illness decrease.
- C. Apply a sunscreen before being exposed to the sun.**
- D. Increase the dosage up to 50 mg twice per day if signs of illness don't decrease.

Rationale: Because haloperidol can cause photosensitivity and precipitate severe sunburn, the nurse should instruct the client to apply a sunscreen before exposure to the sun. The nurse also should teach the client to take haloperidol with meals — not 1 hour before — and should instruct the client not to decrease or increase the dosage unless the physician orders it

58. A client with paranoid schizophrenia repeatedly uses profanity during an activity therapy session. Which response by the nurse would be most appropriate?

- A. "Your behavior won't be tolerated. Go to your room immediately."**
- B. "You're just doing this to get back at me for making you come to therapy."
- C. "Your cursing is interrupting the activity. Take time out in your room for 10 minutes."
- D. "I'm disappointed in you. You can't control yourself even for a few minutes."

Rationale: The nurse should set limits on client behavior to ensure a comfortable environment for all clients. The nurse should accept hostile or quarrelsome client outbursts within limits without becoming personally offended, as in option A. Option B is incorrect because it implies that the client's actions reflect feelings toward the staff instead of the client's own misery. Judgmental remarks, such as option D, may decrease the client's self-esteem.

59. Which of the following is one of the advantages of the newer antipsychotic medication risperidone (Risperdal)?

- A. The absence of anticholinergic effects
- B. A lower incidence of extrapyramidal effects**
- C. Photosensitivity and sedation
- D. No incidence of neuroleptic malignant syndrome

Rationale: Risperdal has a lower incidence of extrapyramidal effects than the typical antipsychotics. Risperdal does produce anticholinergic effects and neuroleptic malignant syndrome can occur. Photosensitivity isn't an advantage.

60. The etiology of schizophrenia is best described by:

- A. genetics due to a faulty dopamine receptor.
- B. environmental factors and poor parenting.
- C. structural and neurobiological factors.
- D. a combination of biological, psychological, and environmental factors.**

Rationale: A reliable genetic marker hasn't been determined for schizophrenia. However, studies of twins and adopted siblings have strongly implicated a genetic predisposition. Since the mid-19th century, excessive dopamine activity in the brain has also been

suggested as a causal factor. Communication and the family system have been studied as contributing factors in the development of schizophrenia. Therefore, a combination of biological, psychological, and environmental factors are thought to cause schizophrenia.

61. A client with schizophrenia who receives fluphenazine (Prolixin) develops pseudoparkinsonism and akinesia. What drug would the nurse administer to minimize extrapyramidal symptoms?

- A. benztropine (Cogentin)**
- B. dantrolene (Dantrium)
- C. clonazepam (Klonopin)
- D. diazepam (Valium)

Rationale: Benztropine is an anticholinergic drug administered to reduce extrapyramidal adverse effects in the client taking antipsychotic drugs. It works by restoring the equilibrium between the neurotransmitters acetylcholine and dopamine in the central nervous system (CNS). Dantrolene, a hydantoin drug that reduces the catabolic processes, is administered to alleviate the symptoms of neuroleptic malignant syndrome, a potentially fatal adverse effect of antipsychotic drugs. Clonazepam, a benzodiazepine drug that depresses the CNS, is administered to control seizure activity. Diazepam, a benzodiazepine drug, is administered to reduce anxiety.

62. A client with a diagnosis of paranoid schizophrenia comments to the nurse, "How do I know what is really in those pills?" Which of the following is the best response?

- A. Say, "You know it's your medicine."
- B. Allow him to open the individual wrappers of the medication.**
- C. Say, "Don't worry about what is in the pills. It's what is ordered."
- D. Ignore the comment because it's probably a joke.

Rationale: Option B is correct because allowing a paranoid client to open his medication can help reduce suspiciousness. Option A is incorrect because the client doesn't know that it's his medication and he's obviously suspicious. Telling the client not to worry or ignoring the comment isn't supportive and doesn't offer reassurance.

63. A client tells the nurse that people from Mars are going to invade the earth. Which response by the nurse would be most therapeutic?

- A. "That must be frightening to you. Can you tell me how you feel about it?"**
- B. "There are no people living on Mars."
- C. "What do you mean when you say they're going to invade the earth?"
- D. "I know you believe the earth is going to be invaded, but I don't believe that."

Rationale: This response addresses the client's underlying fears without feeding the delusion. Refuting the client's delusion, as in option B, would increase anxiety and reinforce the delusion. Asking the client to elaborate on the delusion, as in option C, would also reinforce it. Voicing disbelief about the delusion, as in option D, wouldn't help the client deal with underlying fears

64. A client with schizophrenia tells the nurse he hears the voices of his dead parents. To help the client ignore the voices, the nurse should recommend that he:

- A. sit in a quiet, dark room and concentrate on the voices.
- B. listen to a personal stereo through headphones and sing along with the music.**
- C. call a friend and discuss the voices and his feelings about them.
- D. engage in strenuous exercise.

Rationale: Increasing the amount of auditory stimulation, such as by listening to music through headphones, may make it easier for the client to focus on external sounds and ignore internal sounds from auditory hallucinations. Option A would make it harder for the client to ignore the hallucinations. Talking about the voices, as in option C, would encourage the client to focus on them. Option D is incorrect because exercise alone wouldn't provide enough auditory stimulation to drown out the voices.

65. A client with schizophrenia is receiving antipsychotic medication. Which nursing diagnosis may be appropriate for this client?

- A. Ineffective protection related to blood dyscrasias**
- B. Urinary frequency related to adverse effects of antipsychotic medication
- C. Risk for injury related to a severely decreased level of consciousness
- D. Risk for injury related to electrolyte disturbances

Rationale: Antipsychotic medications may cause neutropenia and granulocytopenia, life-threatening blood dyscrasias, that warrant a nursing diagnosis of Ineffective protection related to blood dyscrasias. These medications also have anticholinergic effects, such as urine retention, dry mouth, and constipation. Urinary frequency isn't an approved nursing diagnosis. Although antipsychotic medications may cause sedation, they don't severely decrease the level of consciousness, eliminating option C. These drugs don't cause electrolyte disturbances, eliminating option D.

66. A client with persistent, severe schizophrenia has been treated with phenothiazines for the past 17 years. Now the client's speech is garbled as a result of drug-induced rhythmic tongue protrusion. What is another name for this extrapyramidal symptom?

- A. Dystonia
- B. Akathisia
- C. Pseudoparkinsonism
- D. Tardive dyskinesia**

Rationale: An adverse reaction to phenothiazines, tardive dyskinesia refers to choreiform tongue movements that commonly are irreversible and may interfere with speech. Dystonia refers to involuntary contraction of a muscle group. Akathisia is restlessness or inability to sit still. Pseudoparkinsonism describes a group of symptoms that mimic those of Parkinson's disease.

67. The nurse is assigned to a client with catatonic schizophrenia. Which intervention

should the nurse include in the client's plan of care?

- A. Meeting all of the client's physical needs**
- B. Giving the client an opportunity to express concerns
- C. Administering lithium carbonate (Lithonate) as prescribed
- D. Providing a quiet environment where the client can be alone

Rationale: Because a client with catatonic schizophrenia can't meet physical needs independently, the nurse must provide for all of these needs, including adequate food and fluid intake, exercise, and elimination. This client is incapable of expressing concerns; however, the nurse should try to verbalize the message conveyed by the client's nonverbal behavior. Lithium is used to treat mania, not catatonic schizophrenia. Despite the client's mute, unresponsive state, the nurse should provide nonthreatening stimulation and should spend time with the client, not leave the client alone all the time. Although aware of the environment, the client doesn't interact with it actively; the nurse's support and presence can be reassuring.

68. A client with a history of medication noncompliance is receiving outpatient treatment for chronic undifferentiated schizophrenia. The physician is most likely to prescribe which medication for this client?

- A. chlorpromazine (Thorazine)
- B. imipramine (Tofranil)
- C. lithium carbonate (Lithane)
- D. fluphenazine decanoate (Prolixin Decanoate)**

Rationale: Fluphenazine decanoate is a long-acting antipsychotic agent given by injection. Because it has a 4-week duration of action, it's commonly prescribed for outpatients with a history of medication noncompliance. Chlorpromazine, also an antipsychotic agent, must be administered daily to maintain adequate plasma levels, which necessitates compliance with the dosage schedule. Imipramine, a tricyclic antidepressant, and lithium carbonate, a mood stabilizer, are rarely used to treat clients with chronic schizophrenia.

69. Propranolol (Inderal) is used in the mental health setting to manage which of the following conditions?

- A. Antipsychotic-induced akathisia and anxiety**
- B. The manic phase of bipolar illness as a mood stabilizer
- C. Delusions for clients suffering from schizophrenia
- D. Obsessive-compulsive disorder (OCD) to reduce ritualistic behavior

Rationale: Propranolol is a potent beta-adrenergic blocker and produces a sedating effect; therefore, it's used to treat antipsychotic induced akathisia and anxiety. Lithium (Lithobid) is used to stabilize clients with bipolar illness. Antipsychotics are used to treat delusions. Some antidepressants have been effective in treating OCD.

70. Every day for the past 2 weeks, a client with schizophrenia stands up during group

therapy and screams, "Get out of here right now! The elevator bombs are going to explode in 3 minutes!" The next time this happens, how should the nurse respond?

- A. "Why do you think there is a bomb in the elevator?"
- B. "That is the same thing you said in yesterday's session."
- C. "I know you think there are bombs in the elevator, but there aren't."**
- D. "If you have something to say, you must do it according to our group rules."

Rationale: Option C is the most therapeutic response because it orients the client to reality. Options A and B are condescending. Option D sounds punitive and could embarrass the client.

71. A 26-year-old client is admitted to the psychiatric unit with acute onset of schizophrenia. His physician prescribes the phenothiazine chlorpromazine (Thorazine), 100 mg by mouth four times per day. Before administering the drug, the nurse reviews the client's medication history. Concomitant use of which drug is likely to increase the risk of extrapyramidal effects?

- A. guanethidine (Ismelin)
- B. droperidol (Inapsine)**
- C. lithium carbonate (Lithonate)
- D. alcohol

Rationale: When administered with any phenothiazine, droperidol may increase the risk of extrapyramidal effects. The other options are incorrect

72. A client, age 36, with paranoid schizophrenia believes the room is bugged by the Central Intelligence Agency and that his roommate is a foreign spy. The client has never had a romantic relationship, has no contact with family members, and hasn't been employed in the last 14 years. Based on Erikson's theories, the nurse should recognize that this client is in which stage of psychosocial development?

- A. Autonomy versus shame and doubt
- B. Generativity versus stagnation
- C. Integrity versus despair
- D. Trust versus mistrust**

Rationale: This client's paranoid ideation indicates difficulty trusting others. The stage of autonomy versus shame and doubt deals with separation, cooperation, and self-control. Generativity versus stagnation is the normal stage for this client's chronologic age. Integrity versus despair is the stage for accepting the positive and negative aspects of one's life, which would be difficult or impossible for this client.

73. During a group therapy session in the psychiatric unit, a client constantly interrupts with impulsive behavior and exaggerated stories that cast her as a hero or princess. She also manipulates the group with attention-seeking behaviors, such as sexual comments and angry outbursts. The nurse realizes that these behaviors are typical of:

- A. paranoid personality disorder.
- B. avoidant personality disorder.
- C. histrionic personality disorder.**
- D. borderline personality disorder.

Rationale: This client's behaviors are typical of histrionic personality disorder, which is marked by excessive emotionality and attention seeking. The client constantly seeks and demands attention, approval, or praise; may be seductive in behavior, appearance, or conversation; and is uncomfortable except when she is the center of attention. Typically, a client with paranoid personality disorder is suspicious, cold, hostile, and argumentative. Avoidant personality disorder is characterized by anxiety, fear, and social isolation. Borderline personality disorder is characterized by impulsive, unpredictable behavior and unstable, intense interpersonal relationships.

74. The nurse is teaching a psychiatric client about her prescribed drugs, chlorpromazine and benztropine. Why is benztropine administered?

- A. To reduce psychotic symptoms
- B. To reduce extrapyramidal symptoms**
- C. To control nausea and vomiting
- D. To relieve anxiety

Rationale: Benztropine is an anticholinergic medication, administered to reduce the extrapyramidal adverse effects of chlorpromazine and other antipsychotic medications. Benztropine doesn't reduce psychotic symptoms, relieve anxiety, or control nausea and vomiting.

75. A client is admitted to the psychiatric unit with a tentative diagnosis of psychosis. Her physician prescribes the phenothiazine thioridazine (Mellaril) 50 mg by mouth three times per day. Phenothiazines differ from central nervous system (CNS) depressants in their sedative effects by producing:

- A. deeper sleep than CNS depressants.
- B. greater sedation than CNS depressants.
- C. a calming effect from which the client is easily aroused.**
- D. more prolonged sedative effects, making the client more difficult to arouse.

Rationale: Shortly after phenothiazine administration, a quieting and calming effect occurs, but the client is easily aroused, alert, and responsive and has good motor coordination.

76. A woman is admitted to the psychiatric emergency department. Her significant other reports that she has difficulty sleeping, has poor judgment, and is incoherent at times. The client's speech is rapid and loose. She reports being a special messenger from the Messiah. She has a history of depressed mood for which she has been taking an antidepressant. The nurse suspects which diagnosis?

- A. Schizophrenia
- B. Paranoid personality

C. Bipolar illness

D. Obsessive-compulsive disorder (OCD)

Rationale: Bipolar illness is characterized by mood swings from profound depression to elation and euphoria. Delusions of grandeur along with pressured speech are common symptoms of mania. Schizophrenia doesn't exhibit mood swings from depression to euphoria. Paranoia is characterized by unrealistic suspiciousness and is often accompanied by grandiosity. OCD is a preoccupation with rituals and rules.

77. A client with paranoid schizophrenia is admitted to the psychiatric unit of a hospital. Nursing assessment should include careful observation of the client's:

A. thinking, perceiving, and decision-making skills.

B. verbal and nonverbal communication processes.

C. affect and behavior.

D. psychomotor activity.

Rationale: Nursing assessment of a psychotic client should include careful inquiry about and observation of the client's thinking, perceiving, symbolizing, and decision-making skills and abilities. Assessment of such a client typically reveals alterations in thought content and process, perception, affect, and psychomotor behavior; changes in personality, coping, and sense of self; lack of self-motivation; presence of psychosocial stressors; and degeneration of adaptive functioning. Although assessing communication processes, affect, behavior, and psychomotor activity would reveal important information about the client's condition, the nurse should concentrate on determining whether the client is hallucinating by assessing thought processes and decision-making ability.

78. Which information is most important for the nurse to include in a teaching plan for a schizophrenic client taking clozapine (Clozaril)?

A. Monthly blood tests will be necessary.

B. Report a sore throat or fever to the physician immediately.

C. Blood pressure must be monitored for hypertension.

D. Stop the medication when symptoms subside.

Rationale: A sore throat and fever are indications of an infection caused by agranulocytosis, a potentially life-threatening complication of clozapine. Because of the risk of agranulocytosis, white blood cell (WBC) counts are necessary **weekly**, not monthly. If the WBC count drops below 3,000/ μ l, the medication must be stopped. Hypotension may occur in clients taking this medication. Warn the client to stand up slowly to avoid dizziness from orthostatic hypotension. The medication should be continued, even when symptoms have been controlled. If the medication must be stopped, it should be slowly tapered over 1 to 2 weeks and only under the supervision of a physician.

79. Important teaching for clients receiving antipsychotic medication such as haloperidol (Haldol) includes which of the following instructions?

- A. Use sunscreen because of photosensitivity.**
- B. Take the antipsychotic medication with food.**
- C. Have routine blood tests to determine levels of the medication.
- D. Abstain from eating aged cheese.

* A and B are both correct in taking HALDOL.

80. Positive symptoms of schizophrenia include which of the following?

- A. Hallucinations, delusions, and disorganized thinking**
- B. Somatic delusions, echolalia, and a flat affect
- C. Waxy flexibility, alogia, and apathy
- D. Flat affect, avolition, and anhedonia

Rationale: The positive symptoms of schizophrenia are distortions of normal functioning. Option A lists the positive symptoms of schizophrenia. A flat affect, alogia, apathy, avolition, and anhedonia refer to the negative symptoms. Negative symptoms list the diminution or loss of normal function

81. A client with chronic schizophrenia receives 20 mg of fluphenazine decanoate (Prolixin Decanoate) by I.M. injection. Three days later, the client has muscle contractions that contort the neck. This client is exhibiting which extrapyramidal reaction?

- A. Dystonia**
- B. Akinesia
- C. Akathisia
- D. Tardive dyskinesia

Rationale: Dystonia, a common extrapyramidal reaction to fluphenazine decanoate, manifests as muscle spasms in the tongue, face, neck, back, and sometimes the legs. Akinesia refers to decreased or absent movement; akathisia, to restlessness or inability to sit still; and tardive dyskinesia, to abnormal muscle movements, particularly around the mouth.

82. Hormonal effects of the antipsychotic medications include which of the following?

- A. Retrograde ejaculation and gynecomastia**
- B. Dysmenorrhea and increased vaginal bleeding
- C. Polydipsia and dysmenorrhea
- D. Akinesia and dysphasia

Rationale: Decreased libido, retrograde ejaculation, and gynecomastia are all hormonal effects that can occur with antipsychotic medications. Reassure the client that the effects can be reversed or that changing medication may be possible. Polydipsia, akinesia, and dysphasia aren't hormonal effects.

83. A client is unable to get out of bed and get dressed unless the nurse prompts every

step. This is an example of which behavior?

- A. Word salad
- B. Tangential
- C. Perseveration
- D. Avolition**

Rationale: Avolition refers to impairment in the ability to initiate goal-directed activity. Word salad is when a group of words are put together in a random fashion without logical connection. Tangential is where a person never gets to the point of the communication. Perseveration is when a person repeats the same word or idea in response to different questions.

84. An agitated and incoherent client, age 29, comes to the emergency department with complaints of visual and auditory hallucinations. The history reveals that the client was hospitalized for paranoid schizophrenia from ages 20 to 21. The physician prescribes haloperidol (Haldol), 5 mg I.M. The nurse understands that this drug is used in this client to treat:

- A. dyskinesia.
- B. dementia.
- C. psychosis.**
- D. tardive dyskinesia.

Rationale: By treating psychosis, haloperidol, an antipsychotic drug, decreases agitation. Haloperidol is used to treat dyskinesia in clients with Tourette syndrome and to treat dementia in elderly clients. Tardive dyskinesia may occur after prolonged haloperidol use; the client should be monitored for this adverse reaction.

85. Yesterday, a client with schizophrenia began treatment with haloperidol (Haldol). Today, the nurse notices that the client is holding his head to one side and complaining of neck and jaw spasms. What should the nurse do?

- A. Assume that the client is posturing.
- B. Tell the client to lie down and relax.
- C. Evaluate the client for adverse reactions to haloperidol.**
- D. Put the client on the list for the physician to see tomorrow.

Rationale: An antipsychotic agent, such as haloperidol, can cause muscle spasms in the neck, face, tongue, back, and sometimes legs as well as torticollis (twisted neck position). The nurse should be aware of these adverse reactions and assess for related reactions promptly. Although posturing may occur in clients with schizophrenia, it isn't the same as neck and jaw spasms. Having the client relax can reduce tension-induced muscle stiffness but not drug-induced muscle spasms. When a client develops a new sign or symptom, the nurse should consider an adverse drug reaction as the possible cause and obtain treatment immediately, rather than have the client wait.

86. A client receiving fluphenazine decanoate (Prolixin Decanoate) therapy develops

pseudoparkinsonism. The physician is likely to prescribe which drug to control this extrapyramidal effect?

- A. phenytoin (Dilantin)
- B. amantadine (Symmetrel)**
- C. benztropine (Cogentin)
- D. diphenhydramine (Benadryl)

Rationale: An antiparkinsonian agent, such as amantadine, may be used to control pseudoparkinsonism; diphenhydramine or benztropine may be used to control other extrapyramidal effects. Phenytoin is used to treat seizure activity.

87. Important teaching for a client receiving risperidone (Risperdal) would include advising the client to:

- A. double the dose if missed to maintain a therapeutic level.
- B. be sure to take the drug with a meal because it's very irritating to the stomach.
- C. discontinue the drug if the client reports weight gain.
- D. notify the physician if the client notices an increase in bruising.**

Rationale: Bruising may indicate blood dyscrasias, so notifying the physician about increased bruising is very important. Don't double the dose. This drug doesn't irritate the stomach, and weight gain isn't a problem.

88. A client is admitted to the psychiatric hospital with a diagnosis of catatonic schizophrenia. During the physical examination, the client's arm remains outstretched after the nurse obtains the pulse and blood pressure, and the nurse must reposition the arm. This client is exhibiting:

- A. suggestibility.
- B. negativity.
- C. waxy flexibility.**
- D. retardation.

Rationale: Waxy flexibility, the ability to assume and maintain awkward or uncomfortable positions for long periods, is characteristic of catatonic schizophrenia. Clients commonly remain in these awkward positions until someone repositions them. Clients with dependency problems may demonstrate suggestibility, a response pattern in which one easily agrees to the ideas and suggestions of others rather than making independent judgments. Negativity (for example, resistance to being moved or being asked to cooperate) and retardation (slowed movement) also occur in catatonic clients.

89. A client with borderline personality disorder becomes angry when he is told that today's psychotherapy session with the nurse will be delayed 30 minutes because of an emergency. When the session finally begins, the client expresses anger. Which response by the nurse would be most helpful in dealing with the client's anger?

- A. "If it had been your emergency, I would have made the other client wait."
- B. "I know it's frustrating to wait. I'm sorry this happened."
- C. "You had to wait. Can we talk about how this is making you feel right now?"**
- D. "I really care about you and I'll never let this happen again."

Rationale: This response may diffuse the client's anger by helping to maintain a therapeutic relationship and addressing the client's feelings. Option A wouldn't address the client's anger. Option B is incorrect because the client with a borderline personality disorder blames others for things that happen, so apologizing reinforces the client's misconceptions. The nurse can't promise that a delay will never occur again, as in option D, because such matters are outside the nurse's control.

90. A client begins clozapine (Clozaril) therapy after several other antipsychotic agents fail to relieve her psychotic symptoms. The nurse instructs her to return for weekly white blood cell (WBC) counts to assess for which adverse reaction?

- A. Hepatitis
- B. Infection
- C. Granulocytopenia**
- D. Systemic dermatitis

Rationale: Clozapine can cause life-threatening neutropenia or granulocytopenia. To detect this adverse reaction, a WBC count should be performed weekly. Hepatitis, infection, and systemic dermatitis aren't adverse reactions of clozapine therapy.

91. Which nonantipsychotic medication is used to treat some clients with schizoaffective disorder?

- A. phenelzine (Nardil)
- B. chlordiazepoxide (Librium)
- C. lithium carbonate (Lithane)**
- D. imipramine (Tofranil)

Rationale: Lithium carbonate, an antimania drug, is used to treat clients with cyclical schizoaffective disorder, a psychotic disorder once classified under schizophrenia that causes affective symptoms, including maniclike activity. Lithium helps control the affective component of this disorder. Phenelzine is a monoamine oxidase inhibitor prescribed for clients who don't respond to other antidepressant drugs such as imipramine. Chlordiazepoxide, an anti-anxiety agent, generally is contraindicated in psychotic clients. Imipramine, primarily considered an antidepressant agent, is also used to treat clients with agoraphobia and those undergoing cocaine detoxification.

92. A client diagnosed with schizoaffective disorder is suffering from schizophrenia with elements of which of the following disorders?

- A. Personality disorder
- B. Mood disorder**
- C. Thought disorder

D. Amnestic disorder

Rationale: According to the DSM-IV, schizoaffective disorder refers to clients suffering from schizophrenia with elements of a mood disorder, either mania or depression. The prognosis is generally better than for the other types of schizophrenia, but it's worse than the prognosis for a mood disorder alone. Option A is incorrect because personality disorders and psychotic illness aren't listed together on the same axis. Option C is incorrect because schizophrenia is a major thought disorder and the question asks for elements of another disorder. Clients with schizoaffective disorder aren't suffering from schizophrenia and an amnestic disorder.

93. When teaching the family of a client with schizophrenia, the nurse should provide which information?

- A. Relapse can be prevented if the client takes the medication.
- B. Support is available to help family members meet their own needs.**
- C. Improvement should occur if the client has a stimulating environment.
- D. Stressful family situations can precipitate a relapse in the client.

Rationale: Because family members of a client with schizophrenia face difficult situations and great stress, the nurse should inform them of support services that can help them cope with such problems. The nurse should also teach them that medication can't prevent relapses and that environmental stimuli may precipitate symptoms. Although stress can trigger symptoms, the nurse shouldn't make the family feel responsible for relapses (as in option D).

94. A client is admitted to the psychiatric unit with active psychosis. The physician diagnoses schizophrenia after ruling out several other conditions. Schizophrenia is characterized by:

- A. loss of identity and self-esteem.
- B. multiple personalities and decreased self-esteem.
- C. disturbances in affect, perception, and thought content and form.**
- D. persistent memory impairment and confusion.

Rationale: The Diagnostic and Statistic Manual of Mental Disorders, 4th edition, defines schizophrenia as a disturbance in multiple psychological processes that affects thought content and form, perception, affect, sense of self, volition, relationship to the external world, and psychomotor behavior. Loss of identity sometimes occurs but is only one characteristic of the disorder. Multiple personalities typify multiple personality disorder, a dissociative personality disorder. Mood disorders are commonly accompanied by increased or decreased self-esteem. Schizophrenia doesn't cause a disturbance in sensorium, although the client may exhibit confusion, disorientation, and memory impairment during the acute phase.

95. The nurse is providing care to a client with a catatonic type of schizophrenia who exhibits extreme negativism. To help the client meet his basic needs, the nurse should:

- A. ask the client which activity he would prefer to do first.
- B. negotiate a time when the client will perform activities.
- C. tell the client specifically and concisely what needs to be done.**
- D. prepare the client ahead of time for the activity.

Rationale: The client needs to be informed of the activity and when it will be done. Giving the client choices isn't desirable because he can be manipulative or refuse to do anything. Negotiating and preparing the client ahead of time also isn't therapeutic with this type of client because he may not want to perform the activity.

96. The nurse is caring for a client who experiences false sensory perceptions with no basis in reality. These perceptions are known as:

- A. delusions.
- B. hallucinations.**
- C. loose associations.
- D. neologisms.

Rationale: Hallucinations are visual, auditory, gustatory, tactile, or olfactory perceptions that have no basis in reality. Delusions are false beliefs, rather than perceptions, that the client accepts as real. Loose associations are rapid shifts among unrelated ideas. Neologisms are bizarre words that have meaning only to the client.

97. The nurse is aware that antipsychotic medications may cause which of the following adverse effects?

- A. Increased production of insulin
- B. Lower seizure threshold**
- C. Increased coagulation time
- D. Increased risk of heart failure

Rationale: Antipsychotic medications exert an effect on brain neurotransmitters that lowers the seizure threshold and can, therefore, increase the risk of seizure activity. Antipsychotics don't affect insulin production or coagulation time. Heart failure isn't an adverse effect of antipsychotic agents

98. A client is admitted with a diagnosis of delusions of grandeur. This diagnosis reflects a belief that one is:

- A. highly important or famous.**
- B. being persecuted.
- C. connected to events unrelated to oneself.
- D. responsible for the evil in the world.

Rationale: A delusion of grandeur is a false belief that one is highly important or famous. A delusion of persecution is a false belief that one is being persecuted. A delusion of reference is a false belief that one is connected to events unrelated to oneself or a belief that one is responsible for the evil in the world.

99. A man with a 5-year history of multiple psychiatric admissions is brought to the emergency department by the police. He was found wandering the streets disheveled, shoeless, and confused. Based on his previous medical records and current behavior, he is diagnosed with chronic undifferentiated schizophrenia. The nurse should assign highest priority to which nursing diagnosis?

- A. **Anxiety**
- B. Impaired verbal communication
- C. Disturbed thought processes
- D. Self-care deficient: Dressing/grooming

Rationale: For this client, the highest-priority nursing diagnosis is Anxiety (severe to panic-level), manifested by the client's extreme withdrawal and attempt to protect himself from the environment. The nurse must act immediately to reduce anxiety and protect the client and others from possible injury. Impaired verbal communication, manifested by noncommunicativeness; Disturbed thought processes, evidenced by inability to understand the situation; and Self-care deficient: Dressing/grooming, evidenced by a disheveled appearance, are appropriate nursing diagnoses but aren't the highest priority

100. A client's medication order reads, "Thioridazine (Mellaril) 200 mg P.O. q.i.d. and 100 mg P.O. p.r.n." The nurse should:

- A. administer the medication as prescribed.
- B. **question the physician about the order.**
- C. administer the order for 200 mg P.O. q.i.d. but not for 100 mg P.O. p.r.n.
- D. administer the medication as prescribed but observe the client closely for adverse effects.

Rationale: The nurse must question this order immediately. Thioridazine (Mellaril) has an absolute dosage ceiling of 800 mg/day. Any dosage above this level places the client at high risk for toxic pigmentary retinopathy, which can't be reversed. As written, the order allows for administering more than the maximum 800 mg/day; it should be corrected immediately, before the client's health is jeopardized.

101. A client is admitted to the psychiatric unit with a diagnosis of borderline personality disorder. The nurse expects the assessment to reveal:

- A. **unpredictable behavior and intense interpersonal relationships.**
- B. inability to function as a responsible parent.
- C. somatic symptoms.
- D. coldness, detachment, and lack of tender feelings.

Rationale: A client with borderline personality disorder displays a pervasive pattern of unpredictable behavior, mood, and self-image. Interpersonal relationships may be intense and unstable and behavior may be inappropriate and impulsive. Although the client's impaired ability to form relationships may affect parenting skills, inability to function as a responsible parent is more typical of antisocial personality disorder. Somatic symptoms

characterize avoidant personality disorder. Coldness, detachment, and lack of tender feelings typify schizoid and schizotypal personality disorders.

102. A client with disorganized type schizophrenia has been hospitalized for the past 2 years on a unit for chronic mentally ill clients. The client's behavior is labile and fluctuates from childishness and incoherence to loud yelling to slow but appropriate interaction. The client needs assistance with all activities of daily living. Which behavior is characteristic of disorganized type schizophrenia?

A. Extreme social impairment

B. Suspicious delusions

C. Waxy flexibility

D. Elevated affect

Rationale: Disorganized type schizophrenia (formerly called hebephrenia) is characterized by extreme social impairment, marked inappropriate affect, silliness, grimacing, posturing, and fragmented delusions and hallucinations. A client with a paranoid disorder typically exhibits suspicious delusions, such as a belief that evil forces are after him. Waxy flexibility, a condition in which the client's limbs remain fixed in uncomfortable positions for long periods, characterizes catatonic schizophrenia. Elevated affect is associated with schizoaffective disorder.

103. The nurse is providing care for a female client with a history of schizophrenia who's experiencing hallucinations. The physician orders 200 mg of haloperidol (Haldol) orally or I.M. every 4 hours as needed. What is the nurse's best action?

A. Administer the haloperidol orally if the client agrees to take it.

B. Call the physician to clarify whether the haloperidol should be given orally or I.M.

C. Call the physician to clarify the order because the dosage is too high.

D. Withhold haloperidol because it may worsen hallucinations.

Rationale: The dosage is too high (normal dosage ranges from 5 to 10 mg daily). Options A and B may lead to an overdose. Option D is incorrect because haloperidol helps with symptoms of hallucinations.

104. A client receiving haloperidol (Haldol) complains of a stiff jaw and difficulty swallowing. The nurse's first action is to:

A. reassure the client and administer as needed lorazepam (Ativan) I.M.

B. administer as needed dose of benztropine (Cogentin) I.M. as ordered.

C. administer as needed dose of benztropine (Cogentin) by mouth as ordered.

D. administer as needed dose of haloperidol (Haldol) by mouth.

Rationale: The client is most likely suffering from muscle rigidity due to haloperidol. I.M. benztropine should be administered to prevent asphyxia or aspiration. Lorazepam treats anxiety, not extrapyramidal effects. Another dose of haloperidol would increase the severity of the reaction.

105. A 24-year-old client is experiencing an acute schizophrenic episode. He has vivid hallucinations that are making him agitated. The nurse's best response at this time would be to:

- A. take the client's vital signs.
- B. explore the content of the hallucinations.**
- C. tell him his fear is unrealistic.
- D. engage the client in reality-oriented activities.

Rationale: Exploring the content of the hallucinations will help the nurse understand the client's perspective on the situation. The client shouldn't be touched, such as in taking vital signs, without telling him exactly what is going to happen. Debating with the client about his emotions isn't therapeutic. When the client is calm, engage him in reality-based activities.

106. Which medication can control the extrapyramidal effects associated with antipsychotic agents?

- A. perphenazine (Trilafon)
- B. doxepin (Sinequan)
- C. amantadine (Symmetrel)**
- D. clorazepate (Tranxene)

Rationale: Amantadine is an anticholinergic drug used to relieve drug-induced extrapyramidal adverse effects, such as muscle weakness, involuntary muscle movement, pseudoparkinsonism, and tardive dyskinesia. Other anticholinergic agents used to control extrapyramidal reactions include benzotropine mesylate (Cogentin), trihexyphenidyl (Artane), biperiden (Akineton), and diphenhydramine (Benadryl). Perphenazine is an antipsychotic agent; doxepin, an antidepressant; and chlorazepate, an anti-anxiety agent. Because these medications have no anticholinergic or neurotransmitter effects, they don't alleviate extrapyramidal reactions.

107. A client with paranoid schizophrenia has been experiencing auditory hallucinations for many years. One approach that has proven to be effective for hallucinating clients is to:

- A. take an as-needed dose of psychotropic medication whenever they hear voices.
- B. practice saying "Go away" or "Stop" when they hear voices.**
- C. sing loudly to drown out the voices and provide a distraction.
- D. go to their room until the voices go away.

Rationale: Researchers have found that some clients can learn to control bothersome hallucinations by telling the voices to go away or stop. Taking an as-needed dose of psychotropic medication whenever the voices arise may lead to overmedication and put the client at risk for adverse effects. Because the voices aren't likely to go away permanently, the client must learn to deal with the hallucinations without relying on drugs. Although distraction is helpful, singing loudly may upset other clients and would be socially unacceptable after the client is discharged. Hallucinations are most

bothersome in a quiet environment when the client is alone, so sending the client to his room would increase, rather than decrease, the hallucinations.

108. A dystonic reaction can be caused by which of the following medications?

- A. diazepam (Valium)
- B. haloperidol (Haldol)**
- C. amitriptyline (Elavil)
- D. clonazepam (Klonopin)

Rationale: Haloperidol is a phenothiazine and is capable of causing dystonic reactions. Diazepam and clonazepam are benzodiazepines, and amitriptyline is a tricyclic antidepressant. Benzodiazepines don't cause dystonic reactions; however, they can cause drowsiness, lethargy, and hypotension. Tricyclic antidepressants rarely cause severe dystonic reactions; however, they can cause a decreased level of consciousness, tachycardia, dry mouth, and dilated pupils.

109. While pacing in the hall, a client with paranoid schizophrenia runs to the nurse and says, "Why are you poisoning me? I know you work for central thought control! You can keep my thoughts. Give me back my soul!" How should the nurse respond during the early stage of the therapeutic process?

- A. "I'm a nurse. I'm not poisoning you. It's against the nursing code of ethics."
- B. "I'm a nurse, and you're a client in the hospital. I'm not going to harm you."**
- C. "I'm not poisoning you. And how could I possibly steal your soul?"
- D. "I sense anger. Are you feeling angry today?"

Rationale: The nurse should directly orient a delusional client to reality, especially to place and person. Options A and C may encourage further delusions by denying poisoning and offering information related to the delusion. Validating the client's feelings, as in option D, occurs during a later stage in the therapeutic process.