1. A nurse is caring for a patient who has been diagnosed with major depressive disorder. Which of the following is the priority goal for the patient in the initial phase of treatment?

A) Improve self-esteem
B) Increase social interactions
C) Prevent self-harm or suicide
D) Encourage physical activity

Answer: C) Prevent self-harm or suicide

Rationale: In the initial phase of treatment for major depressive disorder, the priority goal is to ensure the safety of the patient by preventing self-harm or suicide. Suicidal ideation is common in patients with depression, and addressing this is critical before working on other goals such as improving self-esteem or encouraging social activity.

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2. A nurse is educating a patient diagnosed with generalized anxiety disorder (GAD) about relaxation techniques. Which statement made by the patient indicates a need for further teaching?

A) “I will focus on deep breathing exercises when I feel anxious.”
B) “I will avoid thinking about things that make me anxious.”
C) “I will use visualization to relax when I feel overwhelmed.”
D) “I will practice progressive muscle relaxation every day.”

Answer: B) “I will avoid thinking about things that make me anxious.”

Rationale: Avoiding thoughts that cause anxiety may reinforce avoidance behavior, which can worsen anxiety in the long term. A more effective approach involves learning to manage and cope with anxiety through relaxation techniques, such as deep breathing, progressive muscle relaxation, and visualization.

3. A nurse is assessing a patient with schizophrenia. The patient is talking about a "voice" that is telling them to harm others. Which action should the nurse take first?

A) Ask the patient if they have a plan to harm others.
B) Encourage the patient to share more about the "voice."
C) Validate the patient's feelings and reassure them.
D) Provide the patient with information about their illness.

Answer: A) Ask the patient if they have a plan to harm others.

Rationale: The nurse's priority action is to assess for safety. The patient's report of hearing voices telling them to harm others is a sign of possible command hallucinations, which can lead to violence. It is crucial to assess whether the patient has a plan to harm others and take appropriate action to ensure safety.

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4. A nurse is caring for a patient diagnosed with bipolar disorder. The patient is currently in a manic episode and states, "I'm going to start my own business, and it's going to be huge!" What is the most appropriate response?

A) "That's a great idea. Can you tell me more about it?"
B) "You seem very excited. Let's talk about how we can make that happen."
C) "That's unrealistic. You need to focus on your treatment right now."
D) "It sounds like you have a lot of energy right now. Let's try to redirect that energy."

Answer: D) "It sounds like you have a lot of energy right now. Let's try to redirect that energy."

Rationale: During a manic episode, patients often have excessive energy and unrealistic plans. The nurse should acknowledge the patient's energy level but also redirect the focus away from grandiose ideas. This helps prevent escalation and encourages the patient to focus on more productive activities.

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5. A patient with post-traumatic stress disorder (PTSD) is experiencing flashbacks. Which of the following interventions is most appropriate?

A) Encourage the patient to relive the traumatic event in a safe environment.
B) Provide grounding techniques to help the patient reconnect with the present moment.
C) Offer medications to sedate the patient and prevent further distress.
D) Minimize any discussions of the trauma to prevent further distress.

Answer: B) Provide grounding techniques to help the patient reconnect with the present moment.

Rationale: Grounding techniques, such as deep breathing or focusing on objects in the environment, help the patient reconnect with the present and reduce the intensity of flashbacks. This is a more effective intervention than encouraging the patient to relive the traumatic event or sedating them with medication.

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6. A nurse is preparing to administer lithium to a patient diagnosed with bipolar disorder. Which of the following lab results would require immediate follow-up?

A) Sodium level of 137 mEq/L
B) Lithium level of 1.0 mEq/L

C) Creatinine level of 2.5 mg/dL
D) Potassium level of 4.2 mEq/L

Answer: C) Creatinine level of 2.5 mg/dL

Rationale: Lithium is excreted through the kidneys, so impaired renal function can lead to lithium toxicity. A creatinine level of 2.5 mg/dL indicates renal impairment and requires immediate follow-up to prevent lithium toxicity. The other lab values are within acceptable ranges for lithium therapy.

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7. A nurse is caring for a patient with obsessive-compulsive disorder (OCD). The patient spends several hours a day performing rituals, such as checking locks and washing hands. What is the best approach for the nurse to take?

A) Encourage the patient to stop the rituals immediately.
B) Set a time limit for the patient to perform the rituals each day.
C) Disallow any rituals during hospitalization.
D) Give positive reinforcement when the patient refrains from performing rituals.

Answer: B) Set a time limit for the patient to perform the rituals each day.

Rationale: In the management of OCD, it is important to gradually decrease the time spent on compulsive rituals. Setting a time limit provides structure and allows the patient to feel a sense of control, while helping them to reduce the frequency of the behaviors over time. Abruptly stopping the rituals may cause increased anxiety.
