

# Child and Adolescent Disorders

# 16

## KEYWORDS

attention-deficit hyperactivity disorder  
(ADHD)

autism

autistic disorder

conduct disorder

mild mental retardation

moderate mental retardation

oppositional defiant disorder (ODD)

profound mental retardation

separation anxiety disorder

severe mental retardation

Tourette's disorder

## PRACTICE QUESTIONS

### Theory

1. Which is a description of the etiology of autism from a genetic perspective?
  1. Parents who have one child diagnosed with autism are at higher risk for having other children with the disorder.
  2. Amygdala abnormality in the anterior portion of the temporal lobe is associated with the diagnosis of autism.
  3. Decreased levels of serotonin have been found in individuals diagnosed with autism.
  4. Congenital rubella is implicated in the predisposition to autistic disorders.
2. Which is a predisposing factor in the diagnosis of autism?
  1. Having a sibling diagnosed with mental retardation.
  2. Congenital rubella.
  3. Dysfunctional family systems.
  4. Inadequate ego development.
3. Which factors does Mahler attribute to the etiology of attention-deficit/hyperactivity disorder?
  1. Genetic factors.
  2. Psychodynamic factors.
  3. Neurochemical factors.
  4. Family dynamic factors.
4. The theory of family dynamics has been implicated as contributing to the etiology of conduct disorders. Which of the following are factors related to this theory? Select all that apply.
  1. Frequent shifting of parental figures.
  2. Birth temperament.
  3. Father absenteeism.
  4. Large family size.
  5. Fixation in the separation individuation phase of development.
5. Which is associated with the etiology of Tourette's disorder from a biochemical perspective?
  1. An inheritable component, as suggested by monozygotic and dizygotic twin studies.
  2. Abnormal levels of several neurotransmitters.
  3. Prenatal complications, including low birth weight.
  4. Enlargement of the caudate nucleus of the brain.

### Nursing Process—Assessment

6. Which developmental characteristic would be expected of an individual with an IQ level of 40?
  1. Independent living with assistance during times of stress.
  2. Academic skill to 6th grade level.
  3. Little, if any, speech development.
  4. Academic skill to 2nd grade level.
7. A client has been diagnosed with an IQ level of 60. Which client social/communication capability would the nurse expect to observe?
  1. The client has almost no speech development and no socialization skills.
  2. The client may experience some limitation in speech and social convention.
  3. The client may have minimal verbal skills, with acting-out behavior.
  4. The client is capable of developing social and communication skills.

8. The nurse on an in-patient pediatric psychiatric unit is admitting a client diagnosed with an autistic disorder. Which would the nurse expect to assess?
  1. A strong connection with siblings.
  2. An active imagination.
  3. Abnormalities in physical appearance.
  4. Absence of language.
9. Which is a DSM-IV-TR criterion for the diagnosis of attention-deficit/hyperactivity disorder?
  1. Inattention.
  2. Recurrent and persistent thoughts.
  3. Physical aggression.
  4. Anxiety and panic attacks.
10. When admitting a child diagnosed with a conduct disorder, which symptom would the nurse expect to assess?
  1. Excessive distress about separation from home and family.
  2. Repeated complaints of physical symptoms such as headaches and stomachaches.
  3. History of cruelty toward people and animals.
  4. Confabulation when confronted with wrongdoing.
11. The nursing instructor is preparing to teach nursing students about oppositional defiant disorder (ODD). Which fact should be included in the lesson plan?
  1. Prevalence of ODD is higher in girls than in boys.
  2. The diagnosis of ODD occurs before the age of 3.
  3. The diagnosis of ODD occurs no later than early adolescence.
  4. The diagnosis of ODD is not a developmental antecedent to conduct disorder.
12. Which of the following signs and symptoms supports a diagnosis of depression in an adolescent? Select all that apply.
  1. Poor self-esteem.
  2. Insomnia and anorexia.
  3. Sexually acting out and inappropriate anger.
  4. Increased serotonin levels.
  5. Exaggerated psychosomatic complaints.

### Nursing Process—Diagnosis

13. A child diagnosed with mild to moderate mental retardation is admitted to the medical/surgical floor for an appendectomy. The nurse observes that the child is having difficulty making desires known. Which nursing diagnosis reflects this client's problem?
  1. Ineffective coping R/T developmental delay.
  2. Anxiety R/T hospitalization and absence of familiar surroundings.
  3. Impaired verbal communication R/T developmental alteration.
  4. Impaired adjustment R/T recent admission to hospital.
14. A child diagnosed with severe mental retardation displays failure to thrive related to neglect and abuse. Which nursing diagnosis would best reflect this situation?
  1. Altered role performance R/T failure to complete kindergarten.
  2. Risk for injury: self-directed R/T poor self esteem.
  3. Altered growth and development R/T inadequate environmental stimulation.
  4. Anxiety R/T ineffective coping skills.
15. A child diagnosed with an autistic disorder makes no eye contact; is unresponsive to staff members; and continuously twists, spins, and head bangs. Which nursing diagnosis would take priority?
  1. Personal identity disorder R/T poor ego differentiation.
  2. Impaired verbal communication R/T withdrawal into self.
  3. Risk for injury R/T head banging.
  4. Impaired social interaction R/T delay in accomplishing developmental tasks.

16. A foster child diagnosed with oppositional defiant disorder is spiteful, vindictive, and argumentative, and has a history of aggression toward others. Which nursing diagnosis would take priority?
  1. Impaired social interaction R/T refusal to adhere to conventional social behavior.
  2. Defensive coping R/T unsatisfactory child-parent relationship.
  3. Risk for violence: directed at others R/T poor impulse control.
  4. Noncompliance R/T a negativistic attitude.
17. A child diagnosed with severe mental retardation becomes aggressive with staff members when faced with the inability to complete simple tasks. Which nursing diagnosis would reflect this client's problem?
  1. Ineffective coping R/T inability to deal with frustration.
  2. Anxiety R/T feelings of powerlessness and threat to self-esteem.
  3. Social isolation R/T unconventional social behavior.
  4. Risk for injury R/T altered physical mobility.
18. A child admitted to an in-patient psychiatric unit is diagnosed with separation anxiety disorder. This child is continually refusing to go to bed at the designated time. Which nursing diagnosis best documents this child's problem?
  1. Noncompliance with rules R/T low self-esteem.
  2. Ineffective coping R/T hospitalization and absence of major attachment figure.
  3. Powerlessness R/T confusion and disorientation.
  4. Risk for injury R/T sleep deprivation.

### Nursing Process—Planning

19. Which short-term outcome would take priority for a client who is diagnosed with moderate mental retardation, and who resorts to self-mutilation during times of peer and staff conflict?
  1. The client will form peer relationships by end of shift.
  2. The client will demonstrate adaptive coping skills in response to conflicts.
  3. The client will take direction without becoming defensive by discharge.
  4. The client will experience no physical harm during this shift.
20. A client diagnosed with moderate mental retardation suddenly refuses to participate in supervised hygiene care. Which short-term outcome would be appropriate for this individual?
  1. The client will comply with supervised hygiene by day 3.
  2. The client will be able to complete hygiene without supervision by day 3.
  3. The client will be able to maintain anxiety at a manageable level by day 2.
  4. The client will accept assistance with hygiene by day 2.
21. Which short-term outcome would be considered a priority for a hospitalized child diagnosed with a chronic autistic disorder who bites self when care is attempted?
  1. The child will initiate social interactions with one caregiver by discharge.
  2. The child will demonstrate trust in one caregiver by day 3.
  3. The child will not inflict harm on self during the next 24-hour period.
  4. The child will establish a means of communicating needs by discharge.
22. A child diagnosed with a conduct disorder is disruptive and noncompliant with rules in the milieu. Which outcome, related to this client's problem, should the nurse expect the client to achieve?
  1. The child will maintain anxiety at a reasonable level by day 2.
  2. The child will interact with others in a socially appropriate manner by day 2.
  3. The child will accept direction without becoming defensive by discharge.
  4. The child will contract not to harm self during this shift.

## Nursing Process—Intervention

23. Which charting entry would document an appropriate nursing intervention for a client diagnosed with profound mental retardation?
1. “Rewarded client with lollipop after independent completion of self-care.”
  2. “Encouraged client to tie own shoelaces.”
  3. “Kept client in line of sight continually during shift.”
  4. “Taught the client to sing the alphabet ‘ABC’ song.”
24. A child diagnosed with autistic disorder has a nursing diagnosis of impaired social interaction R/T shyness and withdrawal into self. Which of the following nursing interventions would be most appropriate to address this problem? Select all that apply.
1. Prevent physical aggression by recognizing signs of agitation.
  2. Allow the client to behave spontaneously, and shelter the client from peers.
  3. Remain with the client during initial interaction with others on the unit.
  4. Establish a procedure for behavior modification with rewards to the client for appropriate behaviors.
  5. Explain to other clients the meaning behind some of the client’s nonverbal gestures and signals.
25. A child diagnosed with an autistic disorder withdraws into self and, when spoken to, makes inappropriate nonverbal expressions. The nursing diagnosis impaired verbal communication is documented. Which intervention would address this problem?
1. Assist the child to recognize separateness during self-care activities.
  2. Use a face-to-face and eye-to-eye approach when communicating.
  3. Provide the child with a familiar toy or blanket to increase feelings of security.
  4. Offer self to the child during times of increasing anxiety.
26. A child diagnosed with oppositional defiant disorder begins yelling at staff members when asked to leave group therapy because of inappropriate language. Which nursing intervention would be appropriate?
1. Administer PRN medication to decrease acting-out behaviors.
  2. Accompany the child to a quiet area to decrease external stimuli.
  3. Institute seclusion following agency protocol.
  4. Allow the child to stay in group therapy to monitor the situation further.
27. A child newly admitted to an in-patient psychiatric unit with a diagnosis of major depressive disorder has a nursing diagnosis of high risk for suicide R/T depressed mood. Which nursing intervention would be most appropriate at this time?
1. Encourage the child to participate in group therapy activities daily.
  2. Engage in one-on-one interactions to assist in building a trusting relationship.
  3. Monitor the child continuously while no longer than an arm’s length away.
  4. Maintain open lines of communication for expression of feelings.

## Nursing Process—Evaluation

28. A client diagnosed with oppositional defiant disorder has an outcome of learning new coping skills through behavior modification. Which client statement indicates that behavioral modification has occurred?
1. “I didn’t hit Johnny. Can I have my Tootsie Roll?”
  2. “I want to wear a helmet like Jane wears.”
  3. “Can I watch television after supper?”
  4. “I want a puppy right now.”

29. A client diagnosed with Tourette's disorder has a nursing diagnosis of social isolation. Which charting entry documents a successful outcome related to this client's problem?
1. "Compliant with instructions to use bathroom before bedtime."
  2. "Made potholder at activity therapy session."
  3. "Able to distinguish right hand from left hand."
  4. "Able to focus on TV cartoons for 30 minutes."
30. A child diagnosed with an autistic disorder has a nursing diagnosis of impaired social interaction. The child is currently making eye contact and allowing physical touch. Which of the following statements addresses the evaluation of this child's behavior?
1. The nurse is unable to evaluate this child's ability to interact socially based on the observed behaviors.
  2. The child is experiencing improved social interaction as evidenced by making eye contact and allowing physical touch.
  3. The nurse is unable to evaluate this child's ability to interact socially because the child has not experienced these behaviors for an extended period.
  4. The child's making eye contact and allowing physical touch are indications of improved personal identity, not improved social interaction.

# PRACTICE QUESTIONS ANSWERS AND RATIONALES

The correct answer number and rationale for why it is the correct answer are given in **boldface blue type**. Rationales for why the other answer options are incorrect are also given, but they are not in boldface type.

## Theory

- 1. Research has revealed strong evidence that genetic factors may play a significant role in the etiology of autism. Studies show that parents who have one child with autism are at an increased risk for having more than one child with the disorder. Also, monozygotic and dizygotic twin studies have provided evidence of genetic involvement.**
- Abnormalities associated with autistic disorders have been found in the area of the amygdala; however, this finding supports a biological, not genetic, etiology.
- Elevated, not decreased, levels of serotonin have been found in individuals diagnosed with autism. Alteration in serotonin levels would support a biological, not genetic, etiology.
- Congenital rubella may be implicated in the predisposition to autistic disorders; however, this identification supports a biological, not genetic, etiology.

**TEST-TAKING HINT:** To select the correct answer, the test taker must note the keywords “genetic perspective.” All answers are correct about the etiology of autistic disorders; however, only “1” is from a genetic perspective.

1. Studies have shown that parents who have one child diagnosed with autism, not mental retardation in general, are at increased risk for having more than one child diagnosed with autism.
- 2. Children diagnosed with congenital rubella, postnatal neurological infections, phenylketonuria, or fragile X syndrome are predisposed to being diagnosed with autism.**
- Most clinicians now believe that bad parenting does not predispose a child to being diagnosed with autism.
- No known psychological factors in the ego development of a child predispose the child to being diagnosed with autism.

**TEST-TAKING HINT:** The test taker must understand that as a result of current research findings, some older psychosocial theories related to the development of autism have lost credibility.

1. Research shows that genetic factors are associated with the etiology of attention-deficit hyperactivity disorder (ADHD); however, these factors are not addressed in Mahler’s theory.

- 2. Mahler’s theory suggests that a child with ADHD has psychodynamic problems. Mahler describes these children as fixed in the symbiotic phase of development. They have not differentiated self from mother. Ego development is retarded, and impulsive behavior, dictated by the id, is manifested.**
- Research shows that neurochemical factors are associated with the etiology of ADHD. A deficit of the neurotransmitters dopamine and norepinephrine has been suggested as a causative factor. However, these factors are not addressed in Mahler’s theory.
- Bowen, not Mahler, proposes that when a dysfunctional spousal relationship exists, the focus of the disturbance is displaced onto the child, whose behavior, in time, begins to reflect the pattern of the dysfunctional system. Family dynamics are a factor in the diagnosis of ADHD. However, these factors are not addressed in Mahler’s theory.

**TEST-TAKING HINT:** To select the correct answer, the test taker must be able to distinguish the concepts of Mahler’s theory from the concepts of other theories that support the etiology of ADHD.

- 1. According to the theory of family dynamics, frequent shifting of parental figures has been implicated as a contributing factor in the predisposition to conduct disorder. An example of frequent shifting of parental figures may include, but is not limited to, divorce, death, and inconsistent foster care.**
- According to a physiological perspective, the term “temperament” refers to personality traits that become evident very early in life and may be present at birth. Evidence suggests an association between difficult temperament in childhood and behavioral problems such as conduct disorder later in life. The concept of birth temperament is not a component of family dynamic theory.
- 3. According to the theory of family dynamics, the absence of a father, or the presence of an alcoholic father, has been implicated as a contributing factor to the diagnosis of conduct disorder.**
- 4. According to the theory of family dynamics, large family size has been implicated as a contributing factor in the predisposition to conduct disorder. The quality of family**

**relationships needs to be assessed for evidence of overcrowding, poverty, neglect, and abuse to determine this risk factor.**

5. Fixation in the separation individuation phase of development addresses conduct disorder from a psychodynamic, not family dynamic, perspective.

**TEST-TAKING HINT:** To select the correct answer, the test taker must be familiar with the theory of family dynamics, and how this theory relates to the etiology of conduct disorder.

5. 1. Monozygotic and dizygotic twin studies suggest that there is an inheritable component to the diagnosis of Tourette's disorder; however, this is from a genetic, not biochemical, etiological perspective.
2. **Abnormalities in levels of dopamine, serotonin, dynorphin, gamma-aminobutyric acid, acetylcholine, and norepinephrine have been associated with Tourette's disorder. This etiology is from a biochemical perspective.**
3. Prenatal complications, which include low birth weight, have been noted to be an etiological implication in the diagnosis of Tourette's disorder; however, these are environmental, not biochemical, factors that contribute to the etiology of the disorder.
4. Enlargement of the caudate nucleus of the brain and decreased cerebral blood flow in the left lenticular nucleus have been found in individuals diagnosed with Tourette's disorder. However, these are structural, not biochemical, factors that contribute to the etiology of the disorder.

**TEST-TAKING HINT:** To select the correct answer, the test taker must note keywords in the question, such as "biochemical perspective." All answers are correct related to the etiology of Tourette's disorder, but only "2" is from a biochemical perspective.

## Nursing Process—Assessment

6. 1. Independent living with assistance during times of stress would be a developmental characteristic expected of an individual diagnosed with mild retardation (IQ level 50 to 70), not of an individual diagnosed with moderate mental retardation.
2. Academic skill to 6th grade level would be a developmental characteristic expected of an individual diagnosed with mild mental retardation (IQ level 50 to 70), not of an individual diagnosed with moderate retardation.

3. Little, if any, speech development would be a developmental characteristic expected of an individual diagnosed with profound mental retardation (IQ level <20), not of an individual diagnosed with moderate retardation.

**4. An IQ level of 40 is within the range of moderate mental retardation (IQ level 35 to 49). Academic skill to 2nd grade level would be a developmental characteristic expected of an individual in this IQ range.**

**TEST-TAKING HINT:** To answer this question, the test taker needs to know the developmental characteristics of the levels of mental retardation by degree of severity. These are categorized by IQ range.

7. 1. A client with profound mental retardation (IQ level <20) would have little, if any, speech development, and no capacity for socialization skills.
2. A client with moderate mental retardation (IQ level 35 to 49) may experience some limitation in speech and social communication. The client also may have difficulty adhering to social convention, which would interfere with peer relationships.
3. A client with severe mental retardation (IQ level 20 to 34) would have minimal verbal skills. Because of this deficit, wants and needs are often communicated by acting-out behavior.
4. **A client with mild mental retardation (IQ level 50 to 70) would be capable of developing social and communication skills. The client would function well in a structured, sheltered setting.**

**TEST-TAKING HINT:** The test taker needs to know the developmental characteristics of mental retardation by degree of severity to answer this question correctly.

8. 1. The nurse would expect to note a disconnection, not a connection, with siblings when assessing a child diagnosed with an autistic disorder. Autism usually is first noticed by the mother when the infant fails to be interested in, or socially responsive to, others.
2. The nurse would expect to note a lack of spontaneous make-believe and imaginative play with no active imagination ability when assessing a child diagnosed with an autistic disorder. These children have a rigid adherence to routines and rituals, and minor changes can produce catastrophic reactions.
3. The nurse would assess a normal, not abnormal, physical appearance in a child diagnosed with autism. These children have a normal



appearance; however, on closer observation, no eye contact or facial expression is noted.

4. **One of the first characteristics that the nurse would note is the client's abnormal language patterning or total absence of language. Children diagnosed with autism display an uneven development of intellectual skills. Impairments are noted in verbal and nonverbal communication. These children cannot use or understand abstract language, and they may make unintelligible sounds or say the same word repeatedly.**

**TEST-TAKING HINT:** To select the correct answer choice, the test taker must recognize the characteristic impairments associated with the diagnosis of autistic disorder.

9. The DSM-IV-TR criteria for attention-deficit hyperactivity disorder (ADHD) are divided into three categories: inattention, hyperactivity, and impulsivity. The list of symptoms under each category is extensive. Six (or more) symptoms of inattention or hyperactivity-impulsivity or both must persist for at least 6 months to a degree that is maladaptive and inconsistent with developmental level.

1. **According to the DSM-IV-TR, inattention, along with hyperactivity and impulsivity, describes the essential criteria of ADHD. Children with this disorder are highly distractible and have extremely limited attention spans.**
2. Recurrent and persistent thoughts are diagnostic criteria for obsessive-compulsive disorder, not ADHD. A child diagnosed with ADHD would have difficulty focusing on a thought for any length of time.
3. The classic characteristic of conduct disorder, not ADHD, is the use of physical aggression in the violation of the rights of others.
4. Anxiety and panic attacks are not a DSM-IV-TR criterion for a diagnosis of ADHD. Although children with this disorder are restless and fidgety, and often act as if "driven by a motor," these behaviors are associated with their boundless energy, not anxiety or panic.

**TEST-TAKING HINT:** To select the correct answer, the test taker must understand the DSM-IV-TR criteria for ADHD.

10. 1. Children diagnosed with conduct disorder have poor peer and family relationships and little concern for others. They lack feelings of guilt and remorse, and would not experience or express distress related to separation from home and family.

2. Children diagnosed with separation anxiety, not conduct disorder, have repeated complaints of physical symptoms, such as headaches and stomachaches, related to fear of separation. A child diagnosed with a conduct disorder is a bully, projects a tough image, and believes his or her aggressiveness is justified. Frequent somatic complaints would be uncharacteristic of a child diagnosed with conduct disorder.
3. **A history of physical cruelty toward people and animals is commonly associated with conduct disorder. These children may bury animals alive and set fires intending to cause harm and damage.**
4. Confabulation is defined as a creative way to fill in gaps in the memory with detailed accounts of fictitious events believed true by the narrator. A child diagnosed with conduct disorder has no memory problem, and would most likely deny or lie, not confabulate, when confronted with wrongdoing.

**TEST-TAKING HINT:** To select the correct answer, the test taker must be familiar with the diagnostic criteria of conduct disorder as defined by the DSM-IV-TR.

11. 1. The prevalence of oppositional defiant disorder (ODD) is higher in boys, not girls.
2. The symptoms of ODD typically are evident by 8, not 3, years of age.
3. **The symptoms of ODD usually appear no later than early adolescence. A child diagnosed with ODD presents with a pattern of negativity, disobedience, and hostile behavior toward authority figures. This pattern of behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.**
4. In a significant proportion of cases, ODD is a developmental antecedent to conduct disorder.

**TEST-TAKING HINT:** To select the correct answer, the test taker must be familiar with the various facts related to the diagnosis of ODD.

12. 1. **A symptom of depression in adolescence is poor self-esteem. Puberty and maturity are gradual process and vary among individuals. An adolescent may experience a lack of self-esteem when his or her expectations of maturity are not met or when they compare themselves unfavorably with peers.**
2. **Eating and sleeping disturbances are common signs and symptoms of depression in adolescents.**

3. **Acting out sexually and expressing inappropriate anger are symptoms of depression in adolescence. The fluctuating hormone levels that accompany puberty contribute to these behaviors. A manifestation of behavioral change that lasts for several weeks is the best indicator of a mood disorder in an adolescent.**
4. A decrease, not an increase, in serotonin levels occurs when an adolescent is experiencing depression.
5. **Exaggerated psychosomatic complaints are symptoms of depression in adolescence. Between the ages of 11 and 16, normal rapid changes to the body occur, and psychosomatic complaints are common. These complaints must be differentiated from the exaggerated psychosomatic complaints that occur in adolescent depression.**

**TEST-TAKING HINT:** To answer this question correctly, the test taker needs to differentiate between the symptoms of depression and the normal physical and psychological changes that occur during childhood and adolescence.

## Nursing Process—Diagnosis

13. 1. Ineffective coping is described as the inability to form a valid appraisal of the stressors, inadequate choices of practiced responses, or inability to use available resources. This child's inability to communicate effectively is not related to ineffective coping.
2. A child with mild to moderate retardation may experience anxiety because of hospitalization and the absence of familiar surroundings; however, the child in this question is not displaying symptoms of anxiety. This child's problem is an inability to communicate desires.
3. **Impaired verbal communication R/T developmental alteration is the appropriate nursing diagnosis for a child diagnosed with mild to moderate mental retardation who is having difficulties making needs and desires understood to staff members. Clients diagnosed with mild to moderate retardation often have deficits in communication.**
4. Impaired adjustment is defined as the inability to modify lifestyle or behavior in a manner consistent with a change in health status. Hospitalization of a child with mild to moderate retardation may precipitate impaired adjustment, but the client problem described in the question indicates impaired communication.

**TEST-TAKING HINT:** The test taker needs to understand that the selection of an appropriate nursing diagnosis for mentally retarded clients depends largely on client behaviors, the extent of the client's capabilities, and the severity of the condition. The test taker must look at the client behaviors described in the question to determine the appropriate nursing diagnosis.

14. Altered growth and development is defined as the state in which an individual demonstrates deviations in norms from his or her age group. This may result from mental retardation or neglect and abuse or both.
  1. A child with severe retardation (IQ level 20 to 34) cannot benefit from academic or vocational training, making this an inappropriate nursing diagnosis for this child.
  2. Because of abuse and neglect, this child may aggressively act out to deal with frustration when needs are not met. However, there is nothing in the question that indicates this child is experiencing self-directed aggression.
3. **The nursing diagnosis of altered growth and development related to inadequate environmental stimulation would best address this child's problem of failure to thrive. Failure to thrive frequently results from neglect and abuse.**
4. A child diagnosed with severe mental retardation would not be expected to have any insight or coping skills. Lack of insight would prevent the child from experiencing anxiety and the need to cope.

**TEST-TAKING HINT:** To answer this question correctly, the test taker needs to match the problem presented in the question with the nursing diagnosis that reflects the client's problem. Other nursing diagnoses may apply to clients diagnosed with severe mental retardation, but only "3" addresses failure to thrive.

15. 1. Children diagnosed with an autistic disorder have difficulty being able to distinguish between self and nonself. Although the nursing diagnosis of personal identity disorder has merit for the future, potential injury from head banging would need to be addressed first.
2. Children diagnosed with an autistic disorder have a delayed or absent ability to receive, process, transmit, or use a system of symbols to communicate. Although the nursing diagnosis of impaired verbal communication has merit for the future, potential injury from head banging would need to be addressed first.
3. **Children diagnosed with an autistic disorder frequently head bang because of neurological alterations, increased anxiety, or**

**catastrophic reactions to changes in the environment. Because the nurse is responsible for ensuring client safety, the nursing diagnosis risk for injury takes priority.**

4. Children diagnosed with an autistic disorder do not form interpersonal relationships with others, and do not respond to or show interest in people. Although the nursing diagnosis of impaired social interaction has merit for the future, potential injury from head banging would need to be addressed first.

**TEST-TAKING HINT:** Although all nursing diagnoses presented may apply to clients diagnosed with autistic disorders, the test taker needs to understand that client safety is always the nurse's primary responsibility. The keywords "head banging" in the question should alert the test taker to choose the nursing diagnosis risk for injury as the priority client problem.

16. 1. Impaired social interaction is defined as the state in which an individual participates in an insufficient or excessive quantity or ineffective quality of social exchange. A child diagnosed with ODD generally displays a negative temperament, including an underlying hostility. Impaired social interaction would be a valid nursing diagnosis for this client; however, because of this child's history, risk for violence: directed at others, not impaired social interaction, would be the priority nursing diagnosis.
2. Defensive coping is defined as the state in which an individual repeatedly projects falsely positive self-evaluation based on a self-protective pattern that defends against underlying perceived threats to positive self-regard. Defensive coping would be a valid nursing diagnosis for this client; however, because of this child's history, risk for violence: directed at others, not defensive coping, would be the priority nursing diagnosis.
3. **Risk for violence: directed at others is defined as behaviors in which an individual demonstrates that he or she can be physically, emotionally, or sexually harmful to others. Children diagnosed with ODD have a pattern of negativistic, spiteful, and vindictive behaviors. The foster child described in the question also has a history of aggression toward others. Because maintaining safety is a critical responsibility of the nurse, risk for violence: directed at others would be the priority nursing diagnosis.**
4. Noncompliance is defined as the extent to which a person's behavior fails to coincide

with a health-promoting or therapeutic plan agreed on by the person or family members (or both) and health-care professional. A child diagnosed with ODD generally displays a negative temperament, denies problems, and exhibits underlying hostility. These characteristics may lead to noncompliance with treatment, but because maintaining safety is a critical responsibility of the nurse, risk for violence: directed at others would be the priority nursing diagnosis.

**TEST-TAKING HINT:** To answer this question correctly, the test taker needs to correlate the data collected during the nursing assessment with the appropriate nursing diagnosis in order of priority. Maintaining safety always is prioritized.

17. 1. **A child diagnosed with severe mental retardation (IQ level 20 to 34) who strikes out at staff members when not being able to complete simple tasks is using aggression to deal with frustration. Ineffective coping related to inability to deal with frustration is the appropriate nursing diagnosis for this child.**
2. A child diagnosed with severe mental retardation probably would not have the cognitive ability to experience feelings of powerlessness, or have the insight to experience deficits in self-esteem. Also, the aggressive behavior described in the question is not reflective of the nursing diagnosis of anxiety.
3. A child diagnosed with severe mental retardation probably would not have the cognitive awareness to isolate self from others. Also, the aggressive behavior described in the question is not reflective of the nursing diagnosis of social isolation.
4. A child diagnosed with severe mental retardation may be at risk for injury because of altered physical mobility. However, the aggressive behavior is indicative of ineffective coping not risk for injury.

**TEST-TAKING HINT:** The test taker must pair the client symptoms described in the question with the problem statement, or nursing diagnosis, that relates to these symptoms. Although "4" may be a safety priority, it is not reflective of the immediate client problem of aggression with staff members.

18. 1. Noncompliance is defined as the extent to which a person's behavior fails to coincide with a health-promoting or therapeutic plan agreed on by the person and family members (or both) and health-care professional. A child diagnosed with separation anxiety may

be reluctant or may refuse to obey rules regarding bedtime; however, this noncompliance would be associated with separation from a major attachment figure, not from low self-esteem.

2. **Ineffective coping is defined as the inability to form a valid appraisal of the stressors, ineffective choices of practice responses, or inability to use available resources. A child diagnosed with separation anxiety often refuses to go to school or bed because of fears of separation from home or from individuals to whom the child is attached. The child in the question is refusing to go to bed as a way to cope with fear and anxiety. The nursing diagnosis of ineffective coping would be an appropriate documentation of this client's problem.**
3. Powerlessness is defined as the perception that one's own action would not significantly affect an outcome—a perceived lack of control over a current situation or immediate happening. The child in the question may be experiencing powerlessness and is refusing to comply with bedtime rules in an effort to gain control. This nursing diagnosis documents the cause of powerlessness as confusion or disorientation, however, and no data are presented that indicate the client is confused or disoriented.
4. Risk for injury is defined as the state in which the individual is at risk of injury as a result of environmental conditions interacting with the individual's adaptive and defensive resources. This could be a valid future nursing diagnosis if the child continues to refuse to sleep, leading to sleep deprivation and placing the client at risk for injury. However, this does not address the client's current problem. This client is coping ineffectively by refusing to adhere to bedtime rules because of separation anxiety.

**TEST-TAKING HINT:** The test taker must read this question carefully to recognize that the question is asking for documentation of the client problem presented in the question, not which client problem takes priority.

## Nursing Process—Planning

19. 1. Because this client is diagnosed with moderate mental retardation, the client would have difficulty adhering to social conventions, which may interfere with the establishment of peer relationships. Expecting the client to form peer relationships by the end of the shift

presents an unrealistic timeframe. Also, this diagnosis does not address the self-mutilation behavior described in the question.

2. Even though self-mutilation is a maladaptive way to cope, clients diagnosed with moderate mental retardation (IQ level 35 to 49) would not be expected to make adaptive coping choices, and so this outcome is unrealistic. Also, this short-term outcome does not have a timeframe and is not measurable.
3. Because this client is diagnosed with moderate mental retardation, the client would have limited speech and communication capabilities, and so taking directions would be an unrealistic short-term outcome.
4. **A child diagnosed with moderate mental retardation who resorts to self-mutilation during times of peer and staff conflict must be protected from self-harm. A realistic, measurable outcome would be that the client would experience no physical harm during this shift.**

**TEST-TAKING HINT:** To answer this question correctly, the test taker must be able to identify and select appropriate outcomes that are based on client behaviors described. Self-mutilation behaviors should lead the test taker to focus on safety-related outcomes.

20. 1. **With appropriately implemented interventions that direct the client back to previously supervised hygiene performance, the short-term outcome of client compliance and participation by day 2 can be a reasonable expectation. To achieve this outcome, interventions might include exploring reasons for non-compliance; maintaining consistency of staff members; or providing the client with familiar objects, such as an old versus new toothbrush.**
2. This outcome is inappropriate because completing hygiene without supervision is an unrealistic expectation for a client diagnosed with moderate mental retardation.
3. This outcome is inappropriate because nothing is presented in the question that indicates the client is experiencing anxiety.
4. This outcome is inappropriate because clients diagnosed with moderate mental retardation can perform their own hygiene activities independently. Supervision, not assistance, would be required.

**TEST-TAKING HINT:** To answer this question correctly, the test taker needs to know the reasonable expectations of clients diagnosed with mental retardation. The degree of severity should deter-

mine realistic outcomes for these clients.

- 21.** 1. It would be unrealistic to expect a child diagnosed with a chronic autistic disorder to initiate social interactions. This outcome also does not address the priority safety problem of self-mutilation.
2. Because of impaired social interaction, a child diagnosed with a chronic autistic disorder would not trust another person easily. The child's demonstrating trust in one caregiver would take considerable time, is unrealistic to expect by day 3, and does not address the priority safety problem of self-mutilation.
- 3. A child diagnosed with a chronic autistic disorder who bites self when care is attempted is at risk for injury R/T self-mutilation. Self-injurious behaviors, such as head banging and hand and arm biting, are used as a means to relieve tension. Considering that the nurse's primary responsibility is client safety, expecting the child to refrain from inflicting self-harm during a 24-hour period is the short-term outcome that should take priority.**
4. A child diagnosed with a chronic autistic disorder would experience difficulties in receiving, processing, transmitting, and using a system of symbols to communicate. Expecting a child to establish a means of communicating needs by discharge is a valid outcome; however, it does not address the priority problem of self-mutilation.

**TEST-TAKING HINT:** To select the correct answer, the test taker must remember that client safety is the nurse's primary responsibility. The client's self-mutilating behavior must be addressed as a priority.

- 22.** All outcomes should be client-centered, specific, realistic, positive, and measurable, and contain a timeframe.
1. In the question, anxiety is not addressed as the child's problem. Anxiety is not a characteristic of children diagnosed with a conduct disorder because these children generally lack feelings of guilt or remorse that might, in other children, lead to anxiety. Also, a "reasonable" level of anxiety is neither specific nor measurable.
2. It is unrealistic to expect this child to interact with others in a socially appropriate manner by day 2. This outcome would, it is hoped, be realized in a longer timeframe.
- 3. Accepting direction without becoming**

**defensive by discharge is a specific, measurable, positive, realistic, client-centered outcome for this child. The disruption and noncompliance with rules on the milieu is this child's defensive coping mechanism. Helping the child to see the correlation between this defensiveness and the child's low self-esteem, anger, and frustration would assist in meeting this outcome.**

4. In the question, self-harm is not addressed as the child's problem. Self-harm is not generally a characteristic of children diagnosed with conduct disorder. These children are far more likely to harm someone or something else and must be closely monitored.

**TEST-TAKING HINT:** To select the correct answer, the test taker must match the client behavior presented in the question with the appropriate outcome. In this question, recognizing that an outcome must be realistic should lead the test taker to eliminate "2."

## Nursing Process—Intervention

- 23.** Clients diagnosed with profound mental retardation have IQ levels that are  $<20$  and have no capacity for independent functioning.
1. A client diagnosed with profound mental retardation (IQ level  $<20$ ) has no capacity for independent functioning and would require constant aid and supervision with hygiene care. Using a reward system as a nursing intervention would be appropriate for a child whose IQ level was 50 to 70, not for a child with an IQ level  $<20$ .
2. A client diagnosed with profound mental retardation (IQ level  $<20$ ) lacks fine and gross motor movements and would be unable to tie shoelaces. This nursing intervention would be appropriate for a child whose IQ level was 35 to 70, not for a child with an IQ level  $<20$ .
- 3. A client diagnosed with profound mental retardation requires constant care and supervision. Keeping this client in line of sight continually during the shift is an appropriate intervention for a child with an IQ level  $<20$ .**
4. A client diagnosed with profound mental retardation (IQ level  $<20$ ) has little, if any, speech development and no capacity for singing. This nursing intervention would be appropriate for a child whose IQ level was 35 to 70, not for a child with an IQ level  $<20$ .

**TEST-TAKING HINT:** To select the correct answer choice, the test taker needs to understand the developmental characteristics of mental retardation by degree of severity and match client deficits with appropriate interventions.

24. 1. This intervention would be appropriate if the client were displaying physical aggression or agitation; however, this client is displaying shyness and withdrawal.
2. Allowing the client to behave spontaneously would hinder the ability of the client to interact with others in a socially appropriate manner and impair social interactions further.
3. **The nurse assumes the role of advocate and social mediator when the nurse remains with the client during initial interactions with others on the unit. The presence of a trusted individual provides a feeling of security and supports the client while learning appropriate socialization skills.**
4. **Positive reinforcements can contribute to desired changes in socialization behaviors. These privileges are individually determined as staff members learn the client's likes and dislikes.**
5. **By explaining to peers the meaning behind some of the client's nonverbal gestures, signals, and communication attempts, the nurse facilitates social interactions. With this understanding, others in the client's social setting would be more receptive to social interactions.**

**TEST-TAKING HINT:** To answer this question correctly, the test taker must look for interventions focused on correcting socialization problems. Other interventions may be appropriate for this client, but they do not address the client's shyness and withdrawal into self.

25. 1. Children diagnosed with an autistic disorder have difficulty distinguishing between self and nonself. Assisting the child to recognize separateness is an intervention associated with the nursing diagnosis of personal identity disorder. Although this nursing intervention is important for this child, it does not relate to the nursing diagnosis of impaired verbal communication.
2. **A child diagnosed with an autistic disorder has impairment in communication affecting verbal and nonverbal skills. Nonverbal communication, such as facial expression, eye contact, or gestures, is often absent or socially inappropriate. Eye-to-eye and face-to-face contact expresses genuine**

**interest in, and respect for, the individual. Using an "en face" approach role-models correct nonverbal expressions.**

3. When a child diagnosed with an autistic disorder becomes anxious and stressed, providing comfort and security is an appropriate and helpful nursing intervention. However, this intervention does not relate to the nursing diagnosis of impaired verbal communication.
4. When a child with an autistic disorder demonstrates expressions of anxiety, such as head banging or hand biting, offering self to child may decrease the need to self-mutilate and increase feelings of security. Although this nursing intervention is important for this individual, it does not relate to the nursing diagnosis of impaired verbal communication.

**TEST-TAKING HINT:** To select the correct answer, the test taker must be able to pair the nursing diagnosis presented in the question with the correct nursing intervention. There always must be a correlation between the stated problem and the nursing action that addresses the problem.

26. 1. Administering a PRN medication, such as an anxiolytic, does not address this child's impaired social interaction, negative temperament, or underlying hostilities. Sedating medication is rarely, if ever, administered to a child for disturbances in behavior.
2. **Accompanying the child to a quiet area to decrease external stimuli is the most beneficial action for this child. This action would aid in decreasing anger and hostility expressed by the child's outburst and inappropriate language. Later, the nurse may sit with the child and develop a system of rewards for compliance with therapy and consequences for noncompliance. This can be accomplished by starting with minimal expectations and increasing these expectations as the child begins to manifest evidence of control and compliance.**
3. Instituting seclusion would be punitive and counterproductive. This action would only serve to increase this child's anger and hostility, and may decrease compliance with further therapy. The nurse always should use interventions that are the least restrictive.
4. Allowing this child to remain in group therapy would not only disrupt the entire group, but also send the message that this behavior is acceptable.

**TEST-TAKING HINT:** To answer this question correctly, the test taker must understand that when managing a child diagnosed with ODD, support,

**understanding, and firm guidelines are critical. These criteria are missing in answers “1,” “3,” and “4.”**

- 27.** 1. This intervention would not be a priority at this time. A child diagnosed with major depressive disorder would be unable to concentrate on, or participate in, group therapy activities. Encouraging group therapy can be introduced when the child’s mood is elevated, and the risk for suicide has been addressed.
2. Although it is necessary to establish rapport and build a trusting relationship with this child, because a one-on-one interaction does not address the safety of this client, it would be inappropriate at this time.
- 3. Keeping a child who is at high risk for suicide safe from self-harm would take immediate priority over any other intervention. Monitoring the child continuously while no longer than an arm’s length away would be an appropriate nursing intervention. This observation would allow the nurse to note self-harm behaviors and intervene immediately if necessary.**
4. Although it is necessary to maintain open lines of communication for expression of feelings with this child, because this intervention does not address the safety of this client, it would be inappropriate at this time.

**TEST-TAKING HINT:** To answer this question correctly, the test taker must remember that client safety is always the nurse’s first priority, especially when clients are at high risk for suicide.

## Nursing Process—Evaluation

- 28.** Behavior modification is defined as a treatment modality aimed at changing undesirable behaviors by using a system of reinforcement to bring about the modifications desired.
- 1. The question infers that the client defensively copes with frustration by lashing out and hitting people. New coping skills have been achieved through behavior modification when the client’s states, “I didn’t hit Johnny. Can I have my Tootsie Roll?” The intervention used to achieve this outcome is a reward system that recognizes and appreciates appropriate behavior, modifying that which was previously unacceptable.**
2. The statement, “I want to wear a helmet like Jane wears,” indicates that the client recog-

nizes and desires the belongings of another child. The statement does not reflect that behavior modification is being used, or that new coping skills have been developed.

3. The statement, “Can I watch television after supper?” is just a simple question asked by the client. The statement does not reflect that behavior modification is being used, or that new coping skills have been developed.
4. The client statement, “I want a puppy right now,” does not reflect that behavior modification is being used, or that new coping skills have been developed.

**TEST-TAKING HINT:** To answer this question correctly, the test taker needs to recognize a statement that indicates that behavior modification is being used, and that it has been used successfully. Only “1” meets both of these criteria.

- 29.** 1. This charting entry documents that a client can cooperate by following instructions; however, the ability to cooperate does not address the client problem of social isolation.
- 2. During activity therapy, clients interact with peers and staff. This participation in a social activity reflects a successful outcome for the nursing diagnosis of social isolation.**
3. The ability to distinguish right from left documents a client’s cognitive ability; however, this cognitive ability does not address the client problem of social isolation.
4. The ability to focus for 30 minutes documents a client’s ability to concentrate; however, this ability does not address the client problem of social isolation.

**TEST-TAKING HINT:** To answer this question correctly, the test taker needs to correlate the nursing diagnosis presented in the question (social isolation) with the charting entry that documents a successful outcome. The only answer choice that addresses social isolation is “2.”

- 30.** 1. The nurse should have no difficulty in evaluating this child’s social interaction based on the child’s ability to make eye contact and allow physical touch. For a child diagnosed with an autistic disorder, this social interaction would represent a major accomplishment.
- 2. By making eye contact and allowing physical touch, this child is experiencing improved social interaction, making this an accurate evaluative statement.**
3. Because the child has made significant progress in overcoming social impairment, as evidenced by making eye contact and

allowing physical touch, the nurse should have no difficulty in evaluating this child's social interaction. A timeframe should not be a factor in this evaluation.

4. The nurse can accurately evaluate improved social interaction by observing the client's ability to maintain eye contact and allow physical touch. These improved behaviors

are associated with social interaction, not personal identity.

**TEST-TAKING HINT:** To select the correct answer, the test taker must understand that making eye contact and allowing physical touch are behaviors that evaluate improved social interaction in children diagnosed with autistic disorders.