

Chapter 3: The Stuart Stress Adaptation Model of Psychiatric Nursing Care Test Bank

MULTIPLE CHOICE

1. Which statement can a nurse use to best describe the Stuart Stress Adaptation Model to someone who is unfamiliar with it?
 - a. “The model recognizes the limitations of the nursing process and organizes treatment along critical pathways.”
 - b. “The model bases psychiatric nursing practice on principles derived from nursing science and establishes generic goals for each discrete stage of psychiatric treatment.”
 - c. “The model integrates biopsychosociocultural, environmental, and legal-ethical aspects of psychiatric nursing care into a unified framework for practice throughout the care continuum.”
 - d. “The model is based primarily on the medical model and organizes psychiatric nursing practice according to discrete treatment stages, selected treatment settings, and legal mandates.”

ANS: C

The Stuart Stress Adaptation Model is holistic, views nature as ordered on a social hierarchy, regards adaptation/maladaptation as distinct from health/illness, relates nursing activities to levels of prevention and the four stages of treatment, is based on standards of psychiatric nursing care and professional performance, and can be used across psychiatric settings throughout the care continuum.

DIF: Cognitive Level: Comprehension

REF: Text Page: 44

TOP: Nursing Process: N/A

MSC: NCLEX: Psychosocial Integrity

2. A nurse states, “I don’t understand why the Stuart Stress Adaptation Model uses both the health/illness and adaptation/maladaptation continua.” The best reply is:
 - a. “The more information that’s contained within the model, the more realistically it represents life.”
 - b. “The model recognizes that nature is ordered as a social hierarchy from simple to complex. The health/illness continuum is a simple concept; the adaptation/maladaptation continuum is more complex.”
 - c. “To integrate the theory of four stages of psychiatric treatment, Stuart had to have a health/illness frame of reference. The adaptation/maladaptation continuum was necessary to complement the holistic framework.”
 - d. “The health/illness continuum reflects a medical world view, whereas the adaptation/maladaptation continuum is derived from nursing’s world view. The two reflect the complementary nature of the nursing and medical models of practice.”

ANS: D

The correct option mimics the explanation provided by the author of the text.

DIF: Cognitive Level: Comprehension

REF: Text Page: 44

TOP: Nursing Process: N/A

MSC: NCLEX: Psychosocial Integrity

3. A patient in the emergency room of a local community hospital is crying uncontrollably and repeating over and over, “He will hurt me if I don’t get away from him. You have to help me, please.” Which of the following interventions reflects attention to care in the manner advocated by the assumptions stated in the Stuart Stress Adaptation Model?
- Getting a health care provider to prescribe a sedative for the patient
 - Asking the patient to provide more details about “what he will do”
 - Beginning the nursing process by conducting a nursing assessment
 - Putting the patient in a quiet room to minimize environmental stimuli

ANS: C

The primary responsibility of the psychiatric nurse according to the fifth assumption of the Stuart Stress Adaptation Model is to use the nursing process, standards of care, and professional performance, which, in this case, should start with a nursing assessment. The remaining options are specific interventions that are determined to be appropriate by the assessment data.

DIF: Cognitive Level: Application
TOP: Nursing Process: Assessment

REF: Text Page: 45
MSC: NCLEX: Psychosocial Integrity

4. An adolescent who belongs to a neighborhood gang has been caught both lying and stealing by a parent. After psychiatric testing determines that the adolescent is able to adequately test reality and has no symptoms of a major psychiatric disorder, the most likely finding will be that the child’s behavior demonstrates:
- healthy deviant.
 - healthy conformist.
 - unhealthy deviant.
 - unhealthy conformist.

ANS: A

Alternative or deviant social behaviors are not necessarily indicative of illness.

DIF: Cognitive Level: Application
TOP: Nursing Process: Assessment

REF: Text Page: 46
MSC: NCLEX: Psychosocial Integrity

5. Which criterion of mental health is a nurse assessing when exploring a patient’s sense of self-determination, balance between dependence and independence, and acceptance of the consequences of behavior?
- Autonomy
 - Integration
 - Reality perception
 - Environmental mastery

ANS: A

These factors relate directly to autonomy, the condition that allows for definition and control over a domain.

DIF: Cognitive Level: Application
TOP: Nursing Process: Assessment

REF: Text Page: 46
MSC: NCLEX: Psychosocial Integrity

6. A patient states, “Sometimes I hear voices when no one else is in the room telling me that people are plotting to hurt me.” This patient is experiencing impairment of which criterion of mental health?

- a. Autonomy
- b. Integration
- c. Reality perception
- d. Environmental mastery

ANS: C

Reality perception is the individual's ability to test assumptions about the world with empirical thought. Hallucinations and delusions indicate problems with reality perception.

DIF: Cognitive Level: Application
TOP: Nursing Process: Assessment

REF: Text Page: 46
MSC: NCLEX: Psychosocial Integrity

7. A nurse documents that a patient is appropriately emotionally responsive, in control, and expresses a unified philosophy of life. This implies that the patient has met the mental health criterion of:
- a. autonomy.
 - b. integration.
 - c. reality perception.
 - d. environmental mastery.

ANS: B

Integration refers to a balance between what is expressed and what is repressed and a regulation of moods and emotions, and it includes the characteristics mentioned in the question.

DIF: Cognitive Level: Application
TOP: Nursing Process: Assessment

REF: Text Page: 46
MSC: NCLEX: Psychosocial Integrity

8. A patient mentions, "No one else I know is mentally ill." What reply would help the patient understand the extent of mental illness?
- a. "You are not unique; many people experience mental illness."
 - b. "Let's concern ourselves with you and getting you well again."
 - c. "Being among people who understand your problem and want to help is what is important."
 - d. "You are truly not alone; almost 50% of adults experience some kind of mental illness."

ANS: D

The question asks for a reply relevant to the extent of mental illness. Denying the patient's expressed concern or minimizing that concern is not therapeutic.

DIF: Cognitive Level: Application
TOP: Nursing Process: Implementation

REF: Text Page: 47
MSC: NCLEX: Psychosocial Integrity

9. On the basis of predictions from the Global Burden of Disease Study, mental health professionals should be most concerned with increasing primary prevention efforts for:
- a. alcohol abuse.
 - b. schizophrenia.
 - c. bipolar disorder.
 - d. major depressive disorder.

ANS: D

The study predicted that by the year 2020, major depressive disorder would become the second leading factor in disease burden worldwide.

DIF: Cognitive Level: Comprehension REF: Text Page: 47
TOP: Nursing Process: Planning MSC: NCLEX: Psychosocial Integrity

10. The spouse of a patient with major depressive disorder tells a nurse, “I feel hopeless about my spouse’s condition. It’s not like a physical illness that he can recover from.” Which response will best reassure the spouse?
- “That’s not true. People with mental illness get well more than 90% of the time.”
 - “While your concerns about your spouse’s recovery are understandable, great strides have been made with the use of new antidepressants.”
 - “It’s not right to try to make comparisons between the effectiveness of treatment of mental and physical illnesses. It’s like comparing apples and oranges.”
 - “New studies show that treatment of depression is effective 65% to 80% of the time, whereas treatments for heart disease and cancer are often only 40% effective.”

ANS: D

The answer is the only option that addresses comparative treatment efficacy, providing data that show that there are physical illnesses with poorer treatment results than the mental illness that the spouse is experiencing. The remaining options do not attempt to provide a response to the spouse’s original statement regarding the comparison between physical and mental illnesses.

DIF: Cognitive Level: Application REF: Text Page: 47
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

11. The greatest barrier to treatment for the mentally ill can be minimized by:
- possessing adequate insurance coverage.
 - implementing effective treatment modalities.
 - employing sufficient numbers of mental health practitioners.
 - formulating appropriate, accurate assessment tools for diagnosis.

ANS: A

The initial barrier to a patient seeking mental health treatment is insufficient or nonexistent health care insurance coverage for the treatment of mental illness. While the other options are factors that have a positive effect on mental health care delivery, they become relevant only after a patient seeks and/or begins treatment.

DIF: Cognitive Level: Comprehension REF: Text Page: 47
TOP: Nursing Process: N/A
MSC: NCLEX: Safe, Effective Care Environment: Management of Care

12. Which predisposing factors most influence mental illness?
- Risk factors that influence a person’s vulnerabilities and the type and amount of resources used to handle stress
 - Biological factors, such as genetic background, general health, nutritional status, and exposure to toxins
 - Psychological factors, such as intelligence, morale, self-concept, motivation, and past experiences

- d. Sociocultural characteristics, such as education, income, occupation, culture, religion, and relatedness

ANS: A

Predisposing factors include biological, psychological, and sociocultural components. Predisposing factors are those that place a person at risk for development of a stress-related disorder.

DIF: Cognitive Level: Comprehension REF: Text Page: 48
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

13. Precipitating stressors are stimuli that:
- society views as being deviant or troublesome.
 - the family views as disruptive or burdensome.
 - the patient views as challenging, threatening, or demanding.
 - the nurse views as noxious, overwhelming, or culturally unacceptable.

ANS: C

Precipitating stressors are stimuli that the individual perceives as challenging, threatening, or demanding. Dealing with them requires extra energy and produces a state of tension and stress.

DIF: Cognitive Level: Comprehension REF: Text Page: 48
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

14. Which individual would a nurse consider to be at the highest risk for the onset of stress-related problems?
- A patient whose beloved parent died 3 months ago and who has lost a job because of corporate restructuring. The patient states, "Living with loss and the threat of loss makes me feel helpless."
 - A patient who was passed over for promotion and quit to start a new business. The patient states, "This is just one of a series of challenges I've faced in my life."
 - A patient who is graduating from college and will be married in one month. The patient states, "I'm anticipating the changes these events will make in my life."
 - A married patient whose new business is growing slowly and who plans to adopt a child. The patient says, "I think I'm in control of my destiny."

ANS: A

The patient who has lost a parent and a job is dealing with two stressful life events that are socially undesirable. The patient's cognitive appraisal of the stressors is that of loss and threat of loss. The patient gives no indication of psychological hardiness. The other people described are dealing with change they perceive as challenging but to which they are committed and over which they have some control. These factors indicate psychological hardiness.

DIF: Cognitive Level: Analysis REF: Text Page: 49
TOP: Nursing Process: Diagnosis|Nursing Process: Analysis
MSC: NCLEX: Psychosocial Integrity

15. A nurse taking the history of a patient diagnosed with depression discovers that the patient has a number of life strains and daily hassles. The patient and patient's spouse argue frequently, the teenage children in the family are rebellious, and there is seldom enough money to meet all the bills. In what way is this information relevant?

- a. Negative life events are more likely to negatively affect physical health than mental health.
- b. Daily hassles are a source of considerable stress and may affect mood more than major misfortunes.
- c. Life strains associated with the work role are most predictive of the development of major depression.
- d. Stressful life events are largely overrated as precipitating stressors that lead to the onset of symptoms.

ANS: B

Research suggests that daily hassles may be better predictors of psychological and physical health than major life events. The more frequent and intense the hassles people reported, the poorer was their overall mental and physical health.

DIF: Cognitive Level: Application REF: Text Page: 49

TOP: Nursing Process: Diagnosis|Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

16. A patient has decided to resign from a job that involved many daily hassles. Using Caplan's theory of response to stress, the patient can be seen to be using:
 - a. behavior that adjusts the patient's appraisal of the stress.
 - b. behavior that allows the patient to escape from the stressful environment.
 - c. intrapsychic behavior in order to defend against unpleasant emotional arousal.
 - d. intrapsychic behavior to come to terms with the event by internal readjustment.

ANS: B

Caplan described four phases of an individual's responses to stressful events. The patient's behavior is representative of Phase 1.

DIF: Cognitive Level: Comprehension REF: Text Page: 50

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

17. A patient newly diagnosed with Chron's disease shares she is spending several hours each week on the Internet seeking information about the illness. The nurse can correctly hypothesize that this patient is initially:
 - a. engaged in a search for meaning.
 - b. devising a new coping strategy.
 - c. making a social attribution.
 - d. making a social comparison.

ANS: A

Social response to stress and illness involves the search for meaning, which is a period of time in which people seek information about their problem. It is only after a search for meaning that the patient can begin devising a coping strategy.

DIF: Cognitive Level: Application REF: Text Page: 50

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

18. A major difference between coping resources and coping mechanisms is that:
 - a. coping resources are adaptive, whereas coping mechanisms are usually maladaptive.
 - b. coping resources are assets, whereas coping mechanisms can be assets or

liabilities.

- c. individuals have multiple coping resources, but coping mechanisms are limited in number.
- d. available coping resources are more predictive of outcome than are the coping mechanisms used.

ANS: B

Coping resources include economic assets, abilities, skills, defensive techniques, social supports, and motivation. Coping mechanisms can be defined as any effort directed at stress management and include problem-focused, cognitive-focused, and emotion-focused mechanisms that can be constructive (assets) or destructive (liabilities).

DIF: Cognitive Level: Application REF: Text Pages: 50-51

TOP: Nursing Process: Diagnosis|Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

19. A comparison of the nursing and medical models of care shows that:
- a. nurses assess disease states and causes.
 - b. physicians assess risk factors and vulnerability.
 - c. nursing intervention focuses on curative treatments.
 - d. nursing diagnoses focus on the effectiveness of coping responses.

ANS: D

Nursing diagnosis is concerned with the adaptive/maladaptive continuum of human responses; medical diagnosis is concerned with the health/illness continuum of health problems. Nurses assess risk factors and look for vulnerabilities; physicians assess disease states and look for causes. Nursing intervention consists of caregiving activities; medical intervention consists of curative treatments.

DIF: Cognitive Level: Comprehension REF: Text Pages: 51-52

TOP: Nursing Process: Diagnosis|Nursing Process: Analysis

MSC: NCLEX: Health Promotion and Maintenance

20. Nursing diagnoses:
- a. provide a way for all health professionals to view a patient holistically and to combat the problem of mind-body dualism.
 - b. complement medical diagnoses and are best described as the patient's behavioral response to stress.
 - c. offer an alternative to health professionals who wish to use complementary treatment modalities in lieu of traditional medical treatment.
 - d. contribute little in the everyday clinical setting but do provide nurses with a common language to use for research on outcomes of standard nursing interventions.

ANS: B

Responses to stress, whether actual or potential, are the subject of nursing diagnoses. Nursing diagnoses complement rather than replace medical diagnoses.

DIF: Cognitive Level: Comprehension REF: Text Pages: 51-52

TOP: Nursing Process: Diagnosis|Nursing Process: Analysis

MSC: NCLEX: Health Promotion and Maintenance

21. The spouse of a patient diagnosed with schizophrenia asks a nurse, "How will I know if my spouse becomes psychotic?" The nurse replies:
- "His behavior will become very unpredictable."
 - "Speech becomes very disorganized and inappropriate."
 - "Social skills are greatly impaired resulting in the tendency to isolate."
 - "He will demonstrate thinking and behaviors that are based in reality."

ANS: C

Patients with psychoses have these characteristics: regressive behavior, personality disintegration, significant reduction in the level of awareness, great difficulty in adequately functioning, and gross impairment in reality testing.

DIF: Cognitive Level: Application REF: Text Page: 52
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

22. The nurse initiates the nursing process for the purpose of managing the psychiatric care for a patient with a maladaptive stress response when:
- admission orders have been written by the admitting physician.
 - diagnostic tests rule out the presences of any organic pathology.
 - the patient relationship with the nurse has been established.
 - the nurse makes initial contact with the patient.

ANS: D

The nursing process begins when the nurse makes the initial contact with the patient regardless of the nature of the patient's illness. The nursing care directed by the nursing process is not dependent totally upon the physician's orders. The nurse-patient relationship evolves as the nurse engages in the nursing process.

DIF: Cognitive Level: Application REF: Text Page: 51
TOP: Nursing Process: Implementation
MSC: NCLEX: Safe, Effective Care Environment: Management of Care

23. A patient became acutely anxious and hysterical in response to the stress of the patient's home being destroyed by fire the previous evening. A nurse assesses the patient's treatment stage as:
- crisis.
 - acute.
 - maintenance.
 - health promotion.

ANS: A

The crisis stage occurs in the first days to weeks after a stressful event.

DIF: Cognitive Level: Application REF: Text Page: 53
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

24. A patient became acutely anxious and hysterical in response to the stress of the patient's home being destroyed by fire the previous evening. The immediate nursing goal for the patient is the:
- patient will be stabilized.
 - illness will go into remission.
 - patient will completely recover.
 - patient will achieve optimal wellness.

ANS: A

According to the Stuart Stress Adaptation Model, the nursing goal for the crisis stage is the stabilization of the patient.

DIF: Cognitive Level: Application
TOP: Nursing Process: Planning

REF: Text Page: 53
MSC: NCLEX: Psychosocial Integrity

25. A delusional patient believes that the accidental death of a child was actually caused by aliens. He has become severely anxious believing he is also in danger. During the acute stage of treatment, the expected outcome of nursing care is the:
- patient will experience symptom relief.
 - nurse will validate the patient's strengths.
 - patient will identify vulnerabilities that led to the symptoms.
 - nurse will focus on the patient's quality of life and well-being.

ANS: A

According to the Stuart Stress Adaptation Model, during the acute stage of treatment, the expected outcome of nursing care is symptom relief.

DIF: Cognitive Level: Application
TOP: Nursing Process: Outcome Identification
MSC: NCLEX: Psychosocial Integrity

REF: Text Page: 53

26. A patient is diagnosed with bipolar disorder and hospitalized. According to the Stuart Stress Adaptation Model, nursing interventions for this stage of treatment will focus on:
- inspiring and validating the patient.
 - managing the environment to provide safety.
 - mutual treatment planning, modeling, and teaching adaptive responses.
 - reinforcement of the patient's adaptive coping responses and advocacy.

ANS: C

According to the Stuart Stress Adaptation Model, mutual treatment planning, modeling, and teaching adaptive responses are appropriate nursing interventions for the acute stage of treatment.

DIF: Cognitive Level: Application
TOP: Nursing Process: Planning

REF: Text Page: 53
MSC: NCLEX: Psychosocial Integrity

27. A patient was diagnosed with bipolar disorder and hospitalized. The symptoms went into remission, and the patient was recently discharged to the community. During this stage of treatment the expected outcome will be that the patient will:
- be safe from harm.
 - experience symptom relief.
 - demonstrate improved functioning.
 - attain an optimal quality of life in the community.

ANS: C

The desired outcome during the maintenance stage of treatment is improved patient functioning.

DIF: Cognitive Level: Application

REF: Text Page: 53

TOP: Nursing Process: Outcome Identification
MSC: NCLEX: Psychosocial Integrity

28. A nurse caring for a patient suspects that the patient has a personality disorder in addition to presenting with maladaptive stress response. To confirm this, the nurse would look in the patient's medical record on the *DSM-IV-TR* Axis:
- I.
 - II.
 - IV.
 - V.

ANS: B

Axis II of the *DSM-IV-TR* will confirm or deny the presence of a diagnosed personality disorder.

DIF: Cognitive Level: Comprehension REF: Text Page: 52
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

29. A nurse caring for a patient wonders how the patient's functioning has been evaluated in the past. To learn this, the nurse would look in the medical record on the *DSM-IV-TR* Axis:
- I.
 - II.
 - IV.
 - V.

ANS: D

Axis V reports the clinician's judgment of the individual's overall level of functioning.

DIF: Cognitive Level: Comprehension REF: Text Page: 52
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

30. A nurse caring for a patient would look at *DSM-IV-TR* Axis III to obtain information about the patient's:
- clinical syndromes.
 - general medical conditions.
 - global assessment of functioning.
 - psychosocial and environmental problems.

ANS: B

Axis III allows the clinician to identify any physical disorder that is potentially relevant to the understanding or treatment of the individual.

DIF: Cognitive Level: Comprehension REF: Text Page: 52
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

MULTIPLE RESPONSE

1. A nurse assessing a patient is interested in the patient's appraisal of a recent divorce as a stressor. To obtain this information, it is important for the nurse to gather data about which of the patient's responses. (Select all that apply.)
- Affective

- b. Behavioral
- c. Physiological
- d. Cognitive
- e. Ethical

ANS: A, B, C, D

Appraisal of a stressor is the processing and comprehension of the stressful situation that takes place on many levels, including cognitive, affective, physiological, behavioral, and social. Ethical responses have little impact on this situation.

DIF: Cognitive Level: Application

REF: Text Pages: 49-50

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity