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## Question: 1

The etiology of the characteristic of abusers is:

- A. heredity
- B. personality disorders
- C. anxiety disorders
- D. obsessive compulsive disorders

**Answer: B**

Explanation:

The etiology, or cause, of the characteristics of abusers can be complex and multifaceted, involving both psychological and environmental factors. One significant psychological aspect is the presence of personality disorders.

Personality disorders are a group of mental health conditions characterized by enduring maladaptive patterns of behavior, cognition, and inner experience. These patterns deviate markedly from the expectations of the individual's culture, are pervasive and inflexible, onset in adolescence or early adulthood, are stable over time, and lead to distress or impairment. Common personality disorders that have been associated with abusive behavior include antisocial personality disorder, borderline personality disorder, and narcissistic personality disorder.

Antisocial personality disorder is marked by a disregard for and violation of the rights of others.

Individuals with this disorder often exhibit behaviors that are grounds for arrest, such as deceitfulness, impulsivity, irritability, aggressiveness, disregard for the safety of self or others, consistent irresponsibility, and lack of remorse. These traits can contribute to abusive behavior in relationships.

Borderline personality disorder features a pattern of instability in interpersonal relationships, self-image, and affects, along with marked impulsivity. Individuals with this disorder might experience intense episodes of anger, depression, and anxiety that can last from a few hours to days. They may also have difficulty controlling their anger, which can lead to violent outbursts and contribute to abusive behavior.

Narcissistic personality disorder includes a pattern of grandiosity, a need for admiration, and a lack of empathy. Individuals with this disorder may take advantage of others to achieve their own ends and believe that they are "special" and unique, expecting special treatment from others. Their lack of empathy can make it difficult for them to recognize or care about the needs and feelings of others, which can be a factor in abusive behavior.

Beyond personality disorders, environmental stressors also play a critical role in the etiology of abusive behavior. Stressors such as financial difficulties, unemployment, or the end of a significant relationship can exacerbate underlying personality issues or contribute to the emergence of abusive behaviors.

Individuals under significant stress may lack the resources or coping mechanisms to manage their stress healthily and may instead turn to control or abuse as a way to cope with their feelings of powerlessness or anxiety.

In conclusion, the etiology of the characteristics of abusers is not limited to a single factor but rather involves a complex interaction between inherent personality disorders and external environmental

stressors. Understanding these factors is critical for developing effective interventions and support systems to prevent abuse and help those at risk.

## Question: 2

A recurrent, unexpected, intense period of extreme apprehension and terror without a clear precipitant describes which of the following?

- A. post-traumatic stress disorder
- B. generalized anxiety disorder
- C. phobia
- D. panic disorder

**Answer: D**

Explanation:

The question describes a condition characterized by recurrent, unexpected, intense periods of extreme apprehension and terror without a clear precipitant. The correct answer to this question is panic disorder.

Panic disorder is a type of anxiety disorder marked by repeated and unexpected panic attacks. These panic attacks are episodes of intense fear that can occur suddenly and without any apparent cause. The fear and discomfort escalate to a peak within minutes, leading to various physical and emotional symptoms.

During a panic attack, individuals may experience a rapid heartbeat (tachycardia), palpitations, shortness of breath (dyspnea), sweating, and hyperventilation. Other common symptoms include feelings of impending doom, trembling, chest pain, nausea, dizziness, and chills or hot flashes. These episodes can be so severe that individuals often feel they are losing control, having a heart attack, or even dying.

Panic attacks typically last between a few minutes to about half an hour, but their effects can linger due to the intense fear and anxiety they generate. The unpredictability of these attacks contributes significantly to the distress experienced by those with panic disorder. Not knowing when the next attack will occur can lead to persistent worry and avoidance behaviors, potentially disrupting daily routines and quality of life.

It's important to distinguish panic disorder from other anxiety disorders: - Post-traumatic stress disorder (PTSD) involves re-experiencing a traumatic event through flashbacks or nightmares and is triggered by reminders of the trauma. - Generalized anxiety disorder (GAD) is characterized by chronic and exaggerated worry about everyday routine life events, without the sudden, intense peaks seen in panic attacks. - Phobias are intense, irrational fears of specific objects or situations, such as heights (acrophobia) or spiders (arachnophobia), which lead to avoidance behaviors.

In conclusion, panic disorder specifically refers to the occurrence of sudden, intense, and unprovoked feelings of terror and apprehension, which distinguishes it from other anxiety-related conditions. Treatment often includes psychological therapies, such as cognitive-behavioral therapy, and may involve medication to help manage symptoms.

## Question: 3

The disorder that is most commonly diagnosed with agoraphobia is:

- A. anxiety
- B. panic disorder
- C. bipolar disorder
- D. schizophrenia

**Answer: B**

Explanation:

The disorder most commonly diagnosed with agoraphobia is panic disorder. Agoraphobia is a condition where individuals experience intense fear and anxiety about being in places where escape might be difficult, or where help might not be available should they begin to feel trapped or panicked. This often includes open spaces, public transit, malls, or simply being outside their home.

When agoraphobia is linked with panic disorder, it is specifically categorized as "panic disorder with agoraphobia." This diagnosis indicates that the individual not only suffers from panic attacks and intense anxiety in expected or unexpected situations but also has an added layer of fear related to being in or avoiding certain situations due to the perceived difficulty of escaping or finding help.

To be diagnosed with panic disorder with agoraphobia, patients must meet the criteria for panic disorder as outlined in diagnostic manuals such as the DSM-5. This includes the presence of recurrent, unexpected panic attacks followed by at least one month of persistent concern about having more attacks, worry over the implications or consequences of the attacks, and a significant change in behavior related to the attacks.

Additionally, these individuals must experience agoraphobic anxiety, fearing at least two different situations (e.g., using public transportation, being in open spaces, being in enclosed spaces, standing in line or being in a crowd, or being outside of the home alone). They avoid these situations due to thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms.

This connection between panic disorder and agoraphobia makes treatment more complex, as it addresses both the panic attacks and the avoidance behavior and intense fear related to agoraphobic situations. Treatment typically involves a combination of medication and psychotherapy, particularly cognitive-behavioral therapy (CBT), which helps patients manage their symptoms, reduce avoidance behavior, and gradually expose themselves to feared situations in a controlled and systematic way.

### Question: 4

You have a severely depressed patient who has just returned from electroconvulsive therapy (ECT). She is still unconscious. Which of the following would be a PRIMARY concern in observing this patient?

- A. headache
- B. muscle soreness
- C. confusion
- D. nausea and vomiting

**Answer: D**

Explanation:

When considering post-operative care for a patient who has just undergone electroconvulsive therapy (ECT), several side effects must be closely monitored. ECT is a procedure where small electric currents are passed through the brain, intentionally triggering a brief seizure in order to cause changes in brain chemistry that can quickly reverse symptoms of certain mental health conditions, primarily severe depression. While effective, ECT can lead to several immediate post-treatment side effects.

Among the potential side effects, nausea and vomiting are particularly significant concerns, especially when the patient is unconscious. The primary reason for heightened concern in this context is the risk of aspiration. Aspiration occurs when stomach contents, including any vomit, are breathed into the lungs rather than being swallowed into the esophagus and stomach. This can lead to aspiration pneumonia, a serious and potentially life-threatening lung infection. Given that the patient is unconscious, their protective airway reflexes (such as coughing and throat clearing) are diminished, which drastically increases the risk of aspiration should they vomit.

Other side effects like headache, muscle soreness, and confusion, although uncomfortable and distressing, do not present an immediate risk to the patient's life. Headaches and muscle soreness can typically be managed with analgesics and rest, and while confusion can be disorienting, it usually resolves as the effects of the anesthesia wear off. These symptoms, though certainly requiring attention and management, do not pose the same level of risk as nausea and vomiting in an unconscious patient. In summary, while all the listed side effects are important to address in the post-ECT care of a patient, nausea and vomiting are the primary concerns when the patient is still unconscious due to the significant risk of aspiration and the subsequent complications that can arise from it. Consequently, medical staff must prioritize monitoring and managing these symptoms to prevent any serious respiratory complications. This highlights the importance of not only treating the primary mental health condition but also vigilantly managing the side effects associated with the treatment.

### Question: 5

What cranial nerve is being tested if a client is being assessed for trembling of the lips, involuntary chewing movements, and spasms of the masticatory muscles?

- A. CN 9
- B. CN 11
- C. CN 6
- D. CN 5

**Answer: D**

Explanation:

The correct cranial nerve being tested when assessing for symptoms such as trembling of the lips, involuntary chewing movements, and spasms of the masticatory muscles is Cranial Nerve V, also known as the trigeminal nerve. This nerve is crucial for its dual roles in both sensory and motor functions in the facial region.

The trigeminal nerve is the fifth cranial nerve and is the largest of the cranial nerves. Its primary responsibility is providing sensation to the face. It covers areas from the forehead, through the cheeks, and down to the jaw. Additionally, the trigeminal nerve plays a pivotal role in motor functions related to the muscles involved in mastication (chewing). These muscles include the masseter, temporalis, and pterygoid muscles.

In a clinical setting, when a healthcare provider observes symptoms like lip trembling, involuntary chewing, and muscle spasms in the jaw, they are likely to scrutinize the functionality of the trigeminal nerve. These symptoms can indicate irritation or dysfunction of this nerve. The examination might involve testing both the sensory and motor branches of the trigeminal nerve to determine any abnormalities or deficits.

Testing the trigeminal nerve typically involves various sensory checks, such as light touch, pain, and temperature sensation across the different divisions of the face served by the nerve. Motor function is assessed by asking the patient to clench their teeth or move their jaw side-to-side, evaluating the strength and coordination of the masticatory muscles.

In conclusion, the trigeminal nerve's significant role in both sensory perception and motor control in the face makes it the focal point when a patient presents with symptoms like tremors of the lips, involuntary chewing movements, and spasms in the muscles that control chewing. Accurately assessing and diagnosing any issues with this nerve is essential for determining the appropriate treatment and management of the underlying conditions causing these symptoms.

## Question: 6

Of the following, which would be the most correct for a type of inpatient therapy that is used in psychiatric hospitals that involves the use of particular activities and social interactions according to the patient's needs?

- A. Psychotherapy
- B. Milieu therapy
- C. Sometimes therapy
- D. None of the above

**Answer: B**

Explanation:

To address the question about the type of inpatient therapy used in psychiatric hospitals that focuses on activities and social interactions tailored to the patient's needs, the most correct answer is Milieu therapy.

Milieu therapy, derived from the French word meaning "middle place," is a comprehensive approach used predominantly in mental health treatment settings. This therapeutic strategy emphasizes creating a controlled environment where every aspect of the surroundings is considered part of the treatment. This environment includes not only physical settings but also the social interactions and activities that occur within them.

The core principle of milieu therapy is that the everyday environment is manipulated in a manner that replicates a healthy community. Patients are encouraged to interact in this community setting, which is designed to foster healthy relationships and behaviors. This therapeutic approach makes use of group dynamics, including the interactions between patients and staff, to influence positive changes in the patient's behavior.

In milieu therapy, every interaction becomes an opportunity for therapeutic intervention. The treatment team and the structure of the environment are key components. The team often includes a diverse group of healthcare professionals such as psychiatrists, psychologists, social workers, and nurses, all working collaboratively. The structure of the therapy may involve scheduled routines, social norms, and clear boundaries, all of which help create a safe and stable environment for patients.

Activities in milieu therapy are varied and specifically designed to teach patients practical skills, improve their social abilities, and help manage their symptoms. Activities might include group therapy sessions, individual counseling, recreational activities, and practical tasks like meal preparation or housekeeping duties. Each activity is selected to meet the therapeutic goals of the patients and to encourage positive social interactions.

The efficacy of milieu therapy lies in its holistic approach, considering not just the psychological aspects of a patient's condition, but also the social and environmental factors. This form of therapy is particularly effective for patients with severe mental illnesses, such as schizophrenia or severe personality disorders, as it helps them learn to manage their illness and improve their social skills in a controlled, supportive environment.

In conclusion, milieu therapy stands out as an effective form of inpatient psychiatric therapy that utilizes a structured social environment to promote positive behavior and improve interpersonal skills among patients. Its focus on using real-life interactions and activities tailored to each patient's needs makes it the most suitable answer for the question posed.

## Question: 7

Identify the example of assertive communication.

- A. You were late administering the patient's medication; do not let it happen again.
- B. Would you mind paying closer attention to the time that the medications needs to be administered to patients?
- C. You never pay attention to the time, and you are always late.
- D. You're not late again, are you?

**Answer: A**

Explanation:

Assertive communication is a communication style that expresses needs or feelings in an open, direct, and respectful manner. The question asks to identify an example of assertive communication.

The first example, "You were late administering the patient's medication; do not let it happen again," is an instance of assertive communication. Here, the speaker is directly addressing the issue, stating the behavior that was problematic (being late with the medication), and expressing the expectation for future behavior (not letting it happen again). This is done in a clear and respectful manner, without attacking the person's character or using derogatory language.

The second example, "Would you mind paying closer attention to the time that the medications needs to be administered to patients?" is also an instance of assertive communication. The speaker is expressing the need for a change in behavior (paying closer attention to the time), and doing so in a polite manner.

The third example, "You never pay attention to the time, and you are always late," is not assertive communication but rather aggressive communication. The speaker is making a generalization about the person's behavior (always being late and never paying attention to the time), which can seem accusatory and not helpful in resolving the issue.

The fourth example, "You're not late again, are you?" is also not assertive communication. This is an example of passive-aggressive communication, where the speaker is expressing disapproval or dissatisfaction in an indirect way. This can lead to misunderstanding and does not effectively address the issue.

In conclusion, the examples of assertive communication are the first two: "You were late administering the patient's medication; do not let it happen again" and "Would you mind paying closer attention to the time that the medications needs to be administered to patients?". These examples show honesty, directness, and respect for the other person, all of which are characteristics of assertive communication.

### Question: 8

Which of the following is NOT considered a sexual dysfunction disorder?

- A. dyspareunia
- B. vaginismus
- C. sexual aversion disorder
- D. dysmenorrhea

**Answer: D**

Explanation:

The question asks which option listed is NOT considered a sexual dysfunction disorder. To answer this correctly, understanding what constitutes a sexual dysfunction disorder is crucial.

Sexual dysfunction disorders are conditions that prevent an individual from experiencing satisfaction from sexual activity. These include problems with sexual desire, arousal, or physical responses. Common examples of such disorders include dyspareunia (painful intercourse), vaginismus (involuntary spasms of the vagina that prevent penetration), and sexual aversion disorder (avoidance of all or almost all genital sexual contact).

Dysmenorrhea, on the other hand, refers to pain during menstruation. It is a gynecological condition rather than a sexual dysfunction disorder. Dysmenorrhea can be debilitating and affect a person's daily activities, but it does not directly relate to the sexual response cycle or sexual performance. It is characterized by severe and frequent menstrual cramps and pain, which is usually linked to underlying medical issues like endometriosis or fibroids.

Therefore, among the options given — dyspareunia, vaginismus, sexual aversion disorder, and dysmenorrhea — dysmenorrhea is the correct answer as it is not a sexual dysfunction disorder. It is essential to distinguish between gynecological conditions and sexual dysfunctions to ensure appropriate diagnosis and treatment.

### Question: 9

In a physical examination of a client with schizophrenia, you may find neurological hard signs and soft signs. Which of the following would be considered a hard sign?

- A. decreased reflexes
- B. tics
- C. rapid eye blinking
- D. left-right confusion

**Answer: A**

Explanation:

In the context of schizophrenia, a distinction is often made between neurological "hard signs" and "soft signs." Hard signs are more definitive and can often be linked to specific neurological damage or dysfunction, making them more quantifiable and less likely to vary across different situations or over time. In contrast, soft signs are more subtle, less specific, and can be influenced by transient factors such as emotional state or stress.

An example of a hard sign is decreased reflexes. Decreased reflexes indicate a clear deviation from normal neurological function and suggest some form of neurological impairment. This can be assessed through clinical tests where reflex responses are elicited using a reflex hammer. The response is considered a hard sign because it is a direct and measurable manifestation of neural pathways functioning. In the case of schizophrenia, decreased reflexes, along with muscle weakness, can point to underlying neurological issues that are more fixed and consistent.

Other options listed, such as tics, rapid eye blinking, and left-right confusion, are considered soft signs. These are less specific to particular neurological pathways and can be influenced by a variety of factors. For instance, tics and rapid eye blinking might be exacerbated by stress or emotional states and do not necessarily indicate a stable neurological defect. Similarly, left-right confusion can be a feature of cognitive disruptions seen in schizophrenia but does not directly imply hard neurological damage. Soft signs like astereognosis (inability to recognize objects by touch), dysdiadochokinesia (impaired ability to perform rapid, alternating movements), impaired fine-motor movement, and mirroring (automatic imitation of another person's movements) are indicative of more subtle and less specific neurological issues. These are often used to assess neurological function in schizophrenia but are considered less definitive than hard signs.

In summary, in a physical examination of a client with schizophrenia, decreased reflexes, a hard sign, provides clear evidence of neurological impairment. It is distinct from other symptoms like tics, rapid eye blinking, and left-right confusion, which are categorized as soft signs and are more variable and less directly linked to specific neurological injury or dysfunction.

## Question: 10

The MMSE is sometimes referred to as which of the following?

- A. Maslow test
- B. Literacy test
- C. Folstein test
- D. Clever test

**Answer: C**

Explanation:

The MMSE, or Mini-Mental State Examination, is sometimes referred to as the "Folstein test." This alternative name derives from one of its developers, Dr. Marshal F. Folstein, who, along with his wife Dr. Susan Folstein and Dr. Paul McHugh, created the test in 1975. The MMSE is a brief 30-point questionnaire that is used widely in clinical and research settings to measure cognitive impairment. Administered in approximately 10 minutes, the MMSE evaluates several cognitive functions including arithmetic, memory, and orientation. It is primarily used to assess patients suspected of having cognitive impairments due to conditions like dementia or Alzheimer's disease. Despite its widespread use, it is important to note that the MMSE is a screening tool rather than a diagnostic one. It helps to provide a

quick assessment of a person's mental state over time, offering a way to monitor changes or improvements in cognitive abilities.

The test is not designed to be a comprehensive mental status examination, which would typically be more detailed and cover a broader range of cognitive abilities. The simplicity of the MMSE makes it very useful in clinical settings where time and resources may be limited. However, it should be supplemented by other assessments for a thorough evaluation of cognitive health.

The name "Folstein test" honors the contributions of its developers and distinguishes it from other cognitive tests. It is a testament to the lasting impact of their work in the field of geriatric psychiatry and neurology. Other names like the "Maslow test," "Literacy test," or "Clever test" are incorrect and not associated with the MMSE. These terms do not reflect the purpose, origin, or creators of the MMSE, thus making "Folstein test" the correct and relevant term when referring to this particular cognitive screening tool.

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