Questions #1-10 refer to the article about equine-assisted psychotherapy (EAP) for eating disorders by DeZutti on pages 24-31.

1. Patients should NOT participate in EAP if:
   A. their heart rate is in the 50-to-60-beats-per-minute range.
   B. their potassium level is 3.9 mEq/L.
   C. they feel dizzy or are orthostatic.
   D. their weight is less than 80% of ideal weight.

2. The theoretical psychological foundation for EAP includes all of the following EXCEPT:
   A. Gestalt therapy.
   B. solution-oriented therapy.
   C. rational emotive therapy.
   D. Freudian-based talk therapy.

3. The following change was made to the Diagnostic and Statistical Manual of Mental Disorders-5 relative to eating disorders:
   A. Amenorrhea is no longer required to meet the criteria for anorexia nervosa.
   B. The criterion for bulimia nervosa requires a minimum average frequency for binge eating and inappropriate compensatory behavior of twice weekly.
   C. Binge eating disorder was removed as a diagnosis.
   D. To be diagnosed with an eating disorder the individual must be older than 15.

4. The suicide rate for individuals with anorexia nervosa is:
   A. 10%.
   B. 20%.
   C. 35%.
   D. 40%.

5. The rate of full recovery for anorexia nervosa is reported to be:
   A. 30%.
   B. 46%.
   C. 55%.
   D. 80%.

6. The nurse’s role in EAP for patients with eating disorders includes:
   A. ensuring that a medical summary, current medications, and allergy list accompanies the patient to therapy.
   B. being alert to medications that can cause heat intolerance.
   C. ensuring that the patients are well hydrated during activities.
   D. all of the above.

7. EAP is:
   A. a horsemanship program involving riding lessons.
   B. the process of analyzing and assessing the horse’s response to human interaction.
   C. a term used to describe an experiential therapy that is conducted by a team.
   D. a proven method of treating all patients with an eating disorder.

8. Research has shown that EAP:
   A. improves self-esteem and confidence.
   B. improves communication and group cohesion.
   C. improves Global Assessment of Functioning scores in children.
   D. all of the above.

9. Individuals with an eating disorder are commonly found to exhibit characteristics of:
   A. perfectionism; low self-esteem; and preoccupation with food, weight, and appearance.
   B. personal boundaries and self-identity that are flexible.
   C. a self-evaluation that is not influenced by body shape and weight.
   D. being easily influenced by others and trusting of those in authority.
10. In the individual example reported in the article, patients became connected to each other and the horses by:
A. using halters and lead ropes to lead the horses through the obstacle course.
B. tying their scarves to each other and the horses and pulling on them.
C. chanting the word “recovery” as they walked with the horses.
D. relying on the staff to assist them with the horses.

Questions #11-20 refer to the article about using a safe kit to decrease self-injury among adolescent inpatients by Loveridge on pages 32-36.

11. The percentage of adolescents receiving mental health treatment who self-injure is reported to be:
A. 10% to 20%.
B. 20% to 40%.
C. 30% to 50%.
D. 40% to 80%.

12. The approximate age of onset for self-injury in teens is:
A. 11 to 12.
B. 13 to 14.
C. 15 to 16.
D. 16 to 17.

13. Functions of self-injury include all of the following EXCEPT:
A. self-punishment.
B. affect regulation/coping with emotional pain.
C. eliciting affection from a loved one.
D. suicide attempt.

14. The most common method of self-injury is:
A. burning.
B. cutting.
C. punching.
D. biting.

15. Inclusion criteria for participation in the safe kit pilot study included all EXCEPT:
A. masturbation leading to self-injury.
B. a history of self-injury in the past 6 months.
C. adolescents ages 13 to 18.
D. those with a history of psychiatric hospital admission.

16. What self-injury screening tool was administered as part of the safe kit pilot study?
A. Self-Mutilation Assessment Tool.
B. Chronic Self-Destructive Scale.
C. Deliberate Self-Harm Inventory 9.
D. ReACT Self-Harm Assessment.

17. Which of the following was not included in the safe kit?
A. Chewing gum.
B. Playdoh®.
C. Stress balls.
D. Bubbles.

18. The safe kit items used most often were:
A. stuffed animals and pillows.
B. Playdoh® and stress balls.
C. journals and comic books.
D. crayons and coloring books.

19. Which of the following was NOT a limitation in the safe kit pilot study?
A. Lack of male participants.
B. Obtaining timely informed consent.
C. Small sample.
D. Staff support.

20. What percentage of safe kit users reported they will “always” use the safe kit at home as a coping skill?
A. 13%.
B. 24%.
C. 37%.
D. 48%.

Questions #21-28 refer to the article about workplace violence in acute psychiatric settings by Allen on pages 37-41.

21. Nursing literature has identified a culture that discourages psychiatric nurses from reporting assaults as a/an:
A. superhero complex.
B. tradition of toughness.
C. expectation of harm.
D. liability issue.

22. In the Staying Safe program, organizational leaders supported the decision making of nurses by:
A. providing counseling for staff and/or patients after an injury occurred.
B. setting aside time to listen to nurses describe dangerous situations that occurred the previous day.
C. reviewing patient records and holding inquiries with staff on the units.
D. developing more structured protocols with input from attorneys, patients, and staff.

23. An initial element of resistance by staff to the Staying Safe concepts was:
A. a belief that it is their job to make sure that “nobody gets hurt.”
B. a belief that administrators were concerned about the bottom line.
C. that time was of the essence in handling out of control patients.
D. increased calls for help as well as lost work time related to assaults.

24. Direct care nursing staff believed they could do a better job if they:
A. made a higher salary.
B. had a lower staff-to-patient ratio.
C. were more empowered to make decisions.
D. had more auxiliary staff on the unit.

25. A strategy that was identified with decreasing the likelihood of patients assaulting staff was:
A. avoiding power struggles.
B. always making sure patients understood the rules.
C. increasing consequences for patients who assaulted staff.
D. more effective use of as-needed medications.

26. Over the past 5 years, measured outcomes of the Staying Safe program have included:
A. decreased number of assaults and staff injuries from assaults.
B. increased calls for help as well as lost work time related to assaults.
C. decreased calls for help and increased lost work time related to assaults.
D. greater staff satisfaction and retention.

27. One common safety analogy helpful in staff acceptance of the idea that “waiting for help is not the same as doing nothing” is:
A. Stop, look, and listen before crossing the street.
B. Always buckle your seat belt before you begin to drive.
C. A stitch in time saves nine.
D. Secure your own oxygen mask first before helping others.

28. Three leadership qualities that promote culture change are:
A. patience, consistency, and consequences.
B. persistence, patience, and commitment.
C. commitment, persistence, and consequences.
D. foresight, education, and experience.

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