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ESTUDIA ONLINE

Next Generation
NCLEX-RN®

STUDENT WORKBOOK

MENTAL HEALTH

NCLEX® EXAM TIPS

- **Understand the different mental health disorders:** Familiarize yourself with the common mental health disorders, their symptoms, and interventions. This will help you answer questions related to mental health disorders.

- **Understand psychopharmacology:** Know the different types of psychiatric medications, their indications, side effects, and nursing interventions. You can expect questions about medication management in the mental health section of the NCLEX.

- **Know the nursing process:** The nursing process is a systematic way of assessing, planning, implementing, and evaluating patient care. It is essential to know the nursing process and how it applies to mental health nursing.

- **Practice therapeutic communication:** Communication is essential in mental health nursing. Practice using therapeutic communication techniques such as active listening, empathy, and clarification.

- **Understand legal and ethical issues:** Understand the legal and ethical issues related to mental health nursing, including informed consent, patient rights, and confidentiality. Be aware of the different laws and regulations governing mental health practice.

- **Take practice exams:** Taking practice exams will help you assess your knowledge, identify your strengths and weaknesses, and get familiar with the exam format.

- **Manage your time:** Manage your time effectively during the exam. Don't spend too much time on one question. If you're unsure about an answer, mark it and move on. You can always come back to it later.

- **Stay calm and focused:** Mental health questions can be challenging and emotionally charged. Stay calm, focused, and objective when answering questions. Remember, the NCLEX is a test of your knowledge and critical thinking skills.

NCLEX® MNEMONICS

SIGECAPS: This is a mnemonic used to remember the criteria for diagnosing major depressive disorder. Each letter stands for a symptom:

- Sleep disturbances
- Interest (loss of)
- Guilt
- Energy (loss of)
- Concentration difficulties
- Appetite changes
- Psychomotor changes
- Suicidal ideation

AEIOU-TIPS: This is a mnemonic used to remember the common side effects of antipsychotic medications:

- Akathisia
- Extrapyramidal symptoms
- Insomnia
- Orthostatic hypotension
- Urinary retention
- Tardive dyskinesia
- Impotence
- Photosensitivity
- Seizures

ABCD: This is a mnemonic used to remember the symptoms of alcohol withdrawal syndrome:

- Anxiety
- Blood pressure changes
- Cravings
- Delirium

DABDA: This is a mnemonic used to remember the stages of grief:

- Denial
- Anger
- Bargaining
- Depression
- Acceptance

Q1 During a group session, a client threatens to "punch every one of you." Which is the appropriate **initial** nursing action?

1. Call security to come to the session immediately.
2. Require the client to leave the group immediately.
3. Remind the client that punching anyone is a reason for being placed into seclusion.
4. Remind the client that talking about personal anger is appropriate, but acting on it is not.

Q2 The nurse is creating a plan of care for a client with an autistic disorder. A behavior modification approach (operant conditioning) is being used to improve communication. Which would the **nurse include** in the plan of care?

1. Promote complete independence in the client.
2. Strengthen the client's ability to manage stress.
3. Reward the client when a desired behavior is performed.
4. Provide consistent negative reinforcement to promote appropriate behaviors.



NOTES:

Q3 A client was raped a few weeks ago but still feels "as if it just happened to me." Which response would the nurse make to the client?

1. "It is very, very hard to get over these types of feelings after being raped."
2. "What do you think you would do to reduce the likelihood that you will be raped again?"
3. "Tell me more about what happened and what causes you to feel as if the rape just occurred."
4. "It's hard, but try to keep a sense of perspective. After all, it's been awhile since the rape occurred."

Q4 The nurse is creating a plan of care for a newly admitted client at high risk for suicide. With the focus of the plan being to promote a safe and **therapeutic environment**, which intervention would the nurse include?

1. Place the client in a private room.
2. Establish a therapeutic relationship.
3. Assign a leadership task to the client.
4. Maintain a distance of 10 inches at all times.

NOTES:

Q5 A client says to the nurse, "The federal guards were sent to kill me." Which is the **best response** by the nurse to the client's concern?

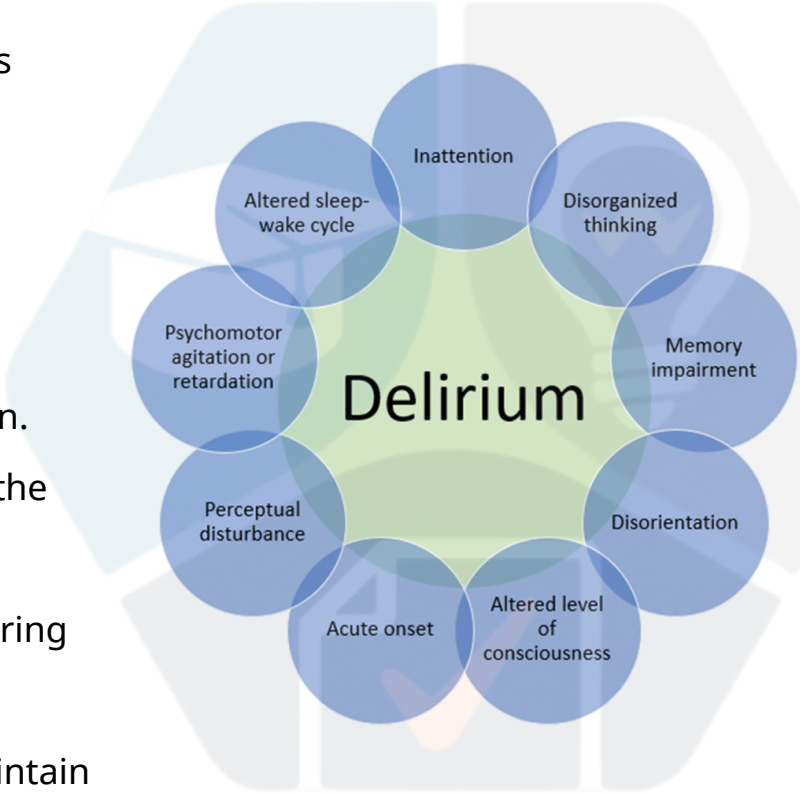
1. "I don't believe this is true."
2. "The guards are not out to kill you."
3. "Do you feel afraid that people are trying to hurt you?"
4. "What makes you think the guards were sent to hurt you?"

Q6 Which nursing interventions are **appropriate** for a hospitalized client with mania who is exhibiting manipulative behavior? Select all that apply.

1. Communicate expected behaviors to the client.
2. Ensure that the client knows that they are not in charge of the nursing unit.
3. Assist the client in identifying ways of setting limits on personal behaviors.
4. Follow through about the consequences of behavior in a nonpunitive manner.
5. Enforce rules by informing the client that they will not be allowed to attend therapy groups.
6. Have the client state the consequences for behaving in ways that are viewed as unacceptable.

NOTES:

Q7 A client diagnosed with delirium becomes disoriented and confused at night. Which intervention would the nurse implement **initially**?



1. Move the client next to the nurses' station.
2. Use an indirect light source and turn off the television.
3. Keep the television and a soft light on during the night.
4. Play soft music during the night, and maintain a well-lit room.

Q8 The nurse observes that a client is pacing, agitated, and presenting aggressive gestures. The client's speech pattern is rapid, and affect is belligerent. Based on these observations, which is the nurse's **immediate priority** of care?

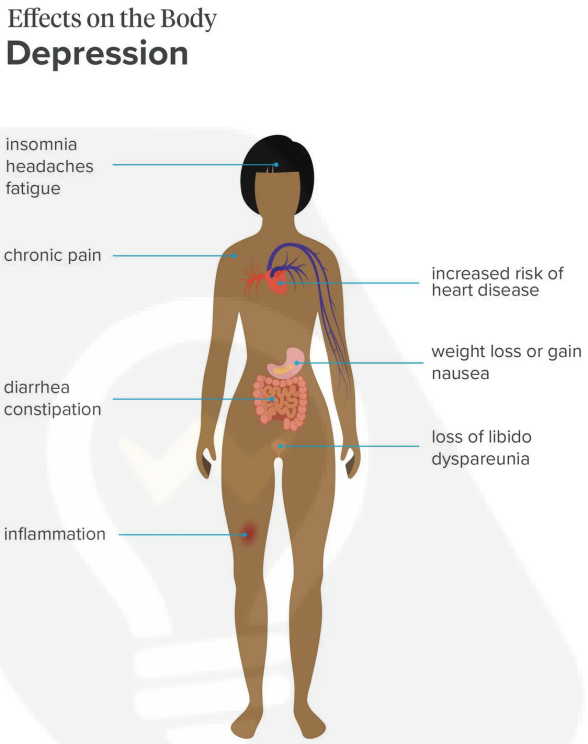
1. Provide safety for the client and other clients on the unit.
2. Provide the clients on the unit with a sense of comfort and safety.
3. Assist the staff in caring for the client in a controlled environment.
4. Offer the client a less stimulating area in which to calm down and gain control.

NOTES:



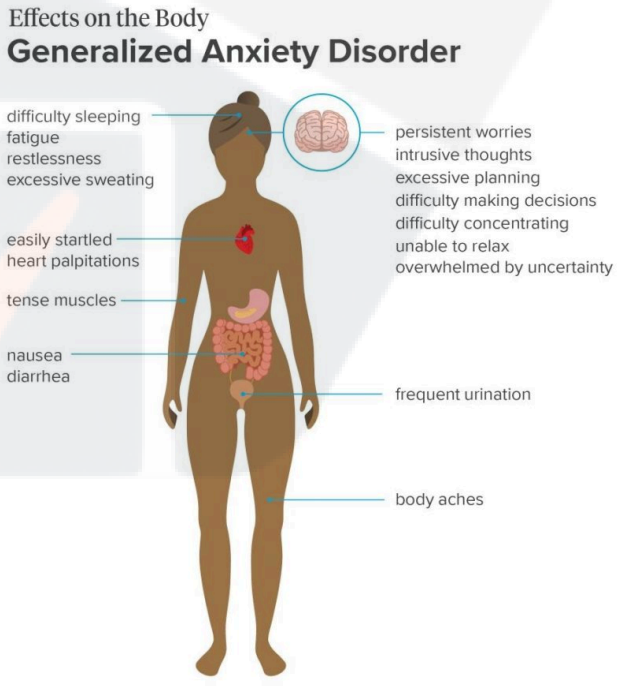
Q9 A client is admitted to the mental health unit with a diagnosis of depression. The nurse would develop a plan of care for the client that **includes which intervention**?

1. Encouraging quiet reading and writing for the first few days
2. Identification of physical activities that will provide exercise
3. No socializing activities until the client asks to participate in milieu
4. A structured program of activities in which the client can participate



Q10 When planning the discharge of a client with chronic anxiety, which is the **most appropriate** maintenance goal?

1. Suppressing feelings of anxiety
2. Identifying anxiety-producing situations
3. Continuing contact with a crisis counselor
4. Eliminating all anxiety from daily situations



NOTES:

Q11 A client is admitted to a medical nursing unit with a diagnosis of acute blindness after being involved in a hit-and-run accident. When diagnostic testing cannot identify any organic reason why this client cannot see, a mental health consult is prescribed. The nurse plans care based on **which mental health condition**?

1. Psychosis
2. Repression
3. Conversion disorder
4. Dissociative disorder

Q12 A manic client begins to make sexual advances toward visitors in the dayroom. When the nurse firmly states that this is inappropriate and will not be allowed, the client becomes verbally abusive and threatens physical violence to the nurse. Based on the analysis of this situation, which **intervention would the nurse implement**?

1. Place the client in seclusion for 30 minutes.
2. Tell the client that the behavior is inappropriate.
3. Escort the client to their room, with the assistance of other staff.
4. Tell the client that their telephone privileges are revoked for 24 hours.

NOTES:

Q13 The nurse is preparing a client with schizophrenia and a history of command hallucinations for **discharge** by providing instructions on interventions for managing hallucinations and anxiety. Which statement in response to these instructions suggests to the nurse that the client has a **need for additional information**?

1. "My medications will help my anxious feelings."
2. "I'll go to support group and talk about what I am feeling."
3. "When I have command hallucinations, I'll call a friend for help."
4. "I need to get enough sleep and eat well to help prevent feeling anxious."

Q14 The nurse is caring for a client diagnosed with paranoid personality disorder who is experiencing disturbed thought processes. In formulating a nursing plan of care, which **best intervention** would the nurse include?

1. Increase socialization of the client with peers.
2. Avoid using a whisper voice in front of the client.
3. Begin to educate the client about social supports in the community.
4. Have the client sign a release of information to appropriate parties for assessment purposes.

NOTES:

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CLINICAL CASE

ITEM 1

Nurses' Notes

1405: 24-year-old client brought to the center by the client's parents for new mental health behaviors. Parents state the client has been under psychiatric care for the past 5 years, but today is a weekend day and the MD office is closed. Client lives in parents' basement and does not attend school or have a job. Spends most of day playing video games and sleeps only a 1 to 2 hours nightly. Seldom eats a full meal and has lost about 20 lb (9.1 kg) over the past few months. Has had several psychotic episodes over the past 5 years, but symptoms have been controlled by drug therapy for 6 months.

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1405: Three days ago, client began dressing in a bizarre manner wearing a cape around the client's shoulders and claiming the ability to save the world from all of its problems. Runs around the neighborhood "looking for people to save." Neighbor frightened by the client's behavior and threatened to call the police last night unless the client controls behavior. Parents feel very frustrated and hopeless.

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ITEM 1

Nurses' Notes

1430: Client bare-chested except for a blue cape. Partial eye mask and blue and red makeup on face and chest. When asked about appearance, states is helping the world fight terrorism. States client was contacted by the Marvel and DC hero team for the client's assistance. When asked how the client was contacted, states heard voices to instruct what to do, but can't recall when that happened. Responses accompanied by inappropriate laughing and grimacing at times. Wants to leave here to "get back to the mission" because the client is very worried that the world is going to end soon.

Highlight the client findings in the nurses'notes that would be of **immediate concern** to the nurse.

ITEM 1

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NOTES:

ITEM 2

The nurse analyzes the client's findings. Indicate which client finding is associated with each client condition. **Each finding is consistent with only one condition.**

Client Finding	Psychosis A	Anxiety B
1. Dressing in a bizarre manner		
2. Heard voices giving instructions		
3.Very worried that the world is going to end		
4. Responses accompanied by inappropriate laughing and grimacing.		
5. Runs around the neighborhood "looking for people to save"		
6. Sleeps only 1-2 hours a night		

ITEM 3

Nurses' Notes

1510: Psychologist interviewed client regarding the client's delusions and possible auditory hallucinations. Client states "has hand weapons hidden in a secret place that are used on heroic missions." Denies alcohol use but enjoys marijuana (smoked and edibles) when the client can afford it. Parents don't want the client smoking in the house.

NOTES:

Complete the following sentence by using the list of options.

ITEM 3

The priority for the client is _____ due to_____.

Select...
1. treating psychosis
2. assessing for anxiety
3. ensuring safety
4. managing delusions

Select...
1. enjoying marijuana (smoked and edibles)
2. dressing in a bizarre manner
3. having a history of psychotic episodes
4. having hand weapons hidden in a secret place

ITEM 4

The nurse continues to communicate with the client using therapeutic techniques. Which statements would be **appropriate** for the nurse at this time? Select all that apply.

1. "Are you still hearing voices?" If so, what are they saying?"
2. "Do you believe that the voices you have heard so far are real?"
3. "Do you believe the world is going to end soon if you don't help?"
4. "Do you feel you get enough sleep, fluids, and nutrition each day?"
5. "Where did you get the hero suit and your weapons?"
6. "Are the hand weapons you have at your parents' house?"
7. "Do you plan on harming yourself or others at this time?"

NOTES:

MY NOTES

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"Every day it's a new opportunity!"

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