NurseAdemy
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 Which interventions are most **appropriate** for caring for a client in alcohol withdrawal? Select all that apply.

1. Monitor vital signs.
2. Provide a safe environment.
3. Address hallucinations therapeutically.
4. Provide stimulation in the environment.
5. Provide reality orientation as appropriate.
6. Maintain NPO (nothing by mouth) status.

Q2 The nurse would monitor the client with a history of heroin addiction for which **signs/symptoms of heroin withdrawal?**

1. Constipation, insomnia, and hallucinations
2. Staggering gait, slurred speech, and violent outbursts
3. Nausea, vomiting, diarrhea, muscle aches, and diaphoresis
4. Decreased heart rate and blood pressure, and dry nose, mouth, and skin.

NOTES:

Q3 A hospitalized client with a history of alcohol abuse tells the nurse, "I am leaving now. I don't want help. I have other things to attend to that are more important." The nurse attempts to discuss the client's concerns, but the client dresses and begins to walk out of the hospital room. **Which action would the nurse take at this time?**

1. Call the nursing supervisor.
2. Call security to block the exits to the nursing unit.
3. Restrain the client, and call the primary health care provider.
4. Tell the client that readmission is not possible after leaving against medical advice.

Q4 The nurse would monitor a client with a history of opioid abuse for which **signs and symptoms associated** with **opioid withdrawal**?

1. Increased appetite, irritability, anxiety, restlessness, and altered concentration
2. Tachycardia, mild hypertension and fever, sweating, nausea, vomiting, and marked tremor
3. Depression, high drug craving, fatigue, altered sleep patterns, hypertension, agitation, and paranoia
4. Increased pulse and blood pressure, low-grade fever, yawning, restlessness, anxiety, diarrhea, and mydriasis

NOTES:

Q5 The nurse working in a detoxification unit is admitting a client for alcohol withdrawal. The client's spouse states, "I don't know why I don't get out of this rotten situation." Which **response by the nurse addresses** the **spouse's concerns**?

1. "This is not a good time to make that decision."
2. "What would your spouse think about your decision?"
3. "What aspects of this situation are the most difficult for you?"
4. "You seem to have a good grip on this situation. You probably need to get out."

Q6 A postsurgical client with a history of heavy alcohol intake has returned to the nursing unit. Which signs/symptoms of **delirium tremens** would the nurse plan to **continuously assess** for?

1. Coarse hand tremor, agitation, hallucinations, and hypotension
2. Hypotension, ataxia, muscular rigidity, and tactile hallucinations
3. Hypotension, stupor, agitation, headache, and auditory hallucinations
4. Fever, hypertension, changes in level of consciousness, and hallucinations

NOTES:

Q7 The home health nurse visits a client at home and determines that the client is dependent on drugs. During the assessment, which action would the nurse take to plan **appropriate** nursing care?

1. Ask the client why they started taking illegal drugs.
2. Ask the client about the amount of drug use and its effect.
3. Ask the client how long they thought that they could take drugs without someone finding out.
4. Not ask any questions for fear that the client is in denial and will throw the nurse out of the home.

Q8 A client is participating in a therapy group and focuses on viewing all team members as equally important in helping the clients meet their goals. The nurse is implementing **which therapeutic approach**?

1. Milieu therapy
2. Interpersonal therapy
3. Behavior modification
4. Support group therapy

NOTES:

Q9 When planning care for a client with a history of violent behavior toward others, the nurse would **include which interventions**? Select all that apply.

1. Providing complete privacy when caring for the client
2. Admitting the client to a room near the nurses' station
3. Avoiding eye contact with the client while providing nursing care
4. Arranging for a security officer to be nearby and available and visible
5. Closing the door to the client's room to ensure privacy when providing direct client care

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Q10 A client receiving tricyclic antidepressants arrives at the mental health clinic. Which **observation** would indicate that **the client is following the medication plan correctly**?

1. Client reports not going to work for the past week.
2. Client complains of not being able to "do anything" anymore.
3. Client arrives at the clinic neat and appropriate in appearance.
4. Client reports sleeping 12 hours per night and 3 to 4 hours during the day.

NOTES:

Q11 A hospitalized client has **begun** taking bupropion as an antidepressant agent. The nurse determines that which is an adverse effect, indicating that the client **is taking an excessive amount** of medication?

1. Constipation
2. Seizure activity
3. Increased weight
4. Dizziness when getting upright

Q12 A client is brought into the emergency department for suspected tricyclic antidepressant overdose. Place the actions that the nurse would take in order of priority. **All options must be used.**

1. Administer oxygen.
2. Check and monitor vital signs.
3. Obtain an electrocardiogram.
4. Check airway and maintain patency.
5. Prepare gastric lavage with activated charcoal.
6. Prepare to administer prescribed medications.



NOTES:

Q13 A client who has been taking buspirone for 1 month returns to the clinic for a follow-up assessment. The nurse determines that the medication is effective if the absence of **which manifestation has occurred**?

1. Paranoid thought process
2. Rapid heartbeat or anxiety
3. Alcohol withdrawal symptoms
4. Thought broadcasting or delusions

Q14 The nurse notes that a client with schizophrenia who is receiving an antipsychotic medication is moving the mouth, protruding the tongue, and grimacing while watching television. The nurse **determines** that the client is experiencing **which medication complication**?

1. Parkinsonism
2. Tardive dyskinesia
3. Hypertensive crisis
4. Neuroleptic malignant syndrome

NOTES:

Q15 The nurse is administering risperidone to a client with schizophrenia who is scheduled to be discharged. **Before discharge,** which instruction would the nurse provide to the client?

1. Get adequate sunlight.
2. Continue driving as usual.
3. Avoid foods rich in potassium.
4. Get up slowly when changing positions.

NOTES:

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CLINICAL CASE

ITEM 1

Nurses' Notes

The nurse performs and documents a screening for a 49-year-old male client who visits the family physician for the client's annual physical examination.

1015: Visit for annual physical examination and flu vaccine today. Married with 2 children, both away at college. Retired from active military service 2 years ago and lives with wife who is a school teacher. States planned to find a part-time job until the pandemic started in 2020. Has no hobbies or interest in pursuing a hobby or job. Describes self as typically active, but for the past 2 months has been sleeping for 11 to 12 hours at night with an afternoon nap most days. Has no energy and spends most days alone, snacking and watching TV. Wife concerned that the client continues to gain weight and "does nothing about it." States retirement has not been what he expected and feels hopeless that life will never get back to normal as a result of the pandemic.

ITEM 1

Based on the nurse's documentation, select 4 client findings which would be of **immediate concern** to the nurse.

1. Retired from military service
2. Has no hobbies or interest in pursuing a hobby or job
3. Sleeping for 11 to 12 hours at night with an afternoon nap
4. Has no energy and spends most days snacking and watching TV
5. Continues to gain weight
6. States retirement has not been what he expected
7. Feels hopeless that life will never get back to normal

NOTES:

Complete the following sentence by using the list of options.

ITEM 2

The nurse analyzes the client findings and determines that the client likely has symptoms of _____ as evidenced by _____, and _____ .

[ ]

Select...
1. dementia
2. anxiety
3. depression
4. personality disorder

[ ]

Select...
1. being retired
2. feeling hopeless
3. gaining weight
4. having no hobbies

[ ]

Select...
1. being alone during the day
2. having no interest
3. having children in college
4. sleeping 11-12 hours a night

Complete the following sentence by using the list of options.

ITEM 3

[ ]

Select...
1. delirium
2. dementia
3. impulse control disorder
4. suicidal ideation
5. depression

[ ]

Select...
1. delirium
2. dementia
3. impulse control disorder
4. suicidal ideation
5. depression

NOTES:

ITEM 3

Nurses' Notes

1020: Wife feels client is depressed. Last week, the client bought two cemetery plots and met with funeral home staff to pay in advance for their funerals. Plans to meet with their lawyer to review their wills and advance directives next week. Says he wants to be prepared for the future to make it easier for her and the family.

ITEM 3

As part of the nurse's interview, the nurse evaluates the client for suicide potential. Which questions would the nurse **include** in this evaluation? Select all that apply.

1. "The information you provided indicates you are depressed. What is that like for you?"
2. "When you feel depressed and alone during the day, what do you think about?"
3. "Have you thought about harming yourself or ending your life?"
4. "If you have thought about harming yourself, do you have a plan?"
5. "Do you have what you need to carry out a plan to harm yourself?""
6. "Why are you feeling so depressed? You have a beautiful family."
7. "Is there anything that might prevent you from carrying out a plan to harm yourself?"
8. "What was the reason you bought cemetery plots and arranged a funeral at your age?"

The nurse compares the client findings from the current nursing assessment to the previous findings in the earlier visit's nurses' notes. Select which current client findings indicate that the client is improving or not improving.

ITEM 4

Current Client Finding	Improving A	Not Improving B
1.Has continued to gain weight since last visit		
2. Sleeps 8 to 9 hours at night and seldom naps		
3. Has more energy and works part-time at local hardware store		
4.Has no hobbies and has no interest in starting one		
5. Feels less hopeless and planning a cruise next year		
6.Spends less time alone watching TV during the day		

MY NOTES

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"Every day it's a new opportunity!"

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