LVN-RN Mental Health NCLEX Practice

1. A nurse is caring for a client who is dying. The client says, "My mother died in the hospital, but I did not get there before she died." Which of the following statements should the nurse make?

   A. "We will call your family in time for them to get here."

   B. "I wonder if you are fearful of dying alone."

   C. "I will make sure a staff member is in your room at all times."

   D. "I will tell your family of your concern so that they can be here."

2. A nurse is caring for a young adult client who says he is experiencing increased anxiety and an inability to concentrate. Which of the following responses should the nurse make?

   A. "It sounds like you're having a difficult time."

   B. "Have you talked to your parents about this yet?"

   C. "Why do you think you are so anxious?"

   D. "How long has this been going on?"

3. A nurse is admitting a client who is in the manic phase of bipolar disorder. The nurse should plan to make which of the following room assignments for the client?

   A. A private room in a quiet location on the unit

   B. A semi-private room with a roommate who has a similar diagnosis

   C. A private room close to the nursing station

   D. A seclusion room until the client’s activity level becomes more subdued.

4. A nurse is admitting a client who has experienced a weight loss of 11 kg (25 lb) in the past 3 months. The client weighs 40 kg (88 lb) and believes she is fat. Which of the following aspects of care should the nurse consider the first priority for this client?

   A. Identify the client's nutritional status.

   B. Request a mental health consult.

   C. Plan a therapeutic diet for the client.

   D. Provide a structured environment for the client.

5. A nurse is caring for a client who has severe manifestations of schizophrenia and is medicated PRN for agitation with haloperidol. The nurse should assess the client for which of the following adverse effects?

   A. Dysrhythmias

   B. Cataracts

   C. Pancreatitis

   D. Bleeding

6. A client becomes very dejected and states, "No one really cares what happens to me. Life isn't worth living anymore." Which of the following responses should the nurse make?

   A. "Of course people care. Your family comes to visit every day."

   B. "Why do you feel that way?"

   C. "Tell me who you think doesn't care about you."

   D. "I care about you, and I am concerned that you feel so sad."

7. A nurse on a mental health unit is caring for a client who has generalized anxiety disorder. The client received a telephone call that was upsetting, and now the client is pacing up and down the corridors of the unit. Which of the following actions should the nurse take?

   A. Instruct the client to sit down and stop pacing.

   B. Allow the client to pace alone until physically tired.

   C. Have a staff member escort the client to her room.

   D. Walk with the client at a gradually slower pace.

8. A nurse is caring for a client who was involved in heavy combat and observed war casualties. The nurse should suspect that the client is suffering from posttraumatic stress disorder (PTSD) if the client makes which of the following statements?

   A. "I check any room I enter because the enemy is still after me and could be hiding anywhere."

   B. "My child was born with a birth defect due to an exposure I had overseas."

   C. "I killed four enemy soldiers with my bare hands and saved my entire battalion."

   D. "In my dreams, all I can see are the wounded reaching out and trying to grab me."

9. A school nurse is talking with a 13-year-old female at her annual health-screening visit. Which of the following comments made by the adolescent should be the nurse's priority to address?

   A. "My parents treat me like a baby sometimes."

   B. "I haven't gotten my period yet, and all my friends have theirs."

   C. "None of the kids at this school like me, and I don't like them either."

   D. "There's a big pimple on my face, and I worry that everyone will notice it."

10. A nurse on a long-term care unit is creating a plan of care for a client who has Alzheimer's disease. Which of the following interventions should the nurse include in the plan?

   A. Rotate assignment of daily caregivers.

   B. Provide an activity schedule that changes from day to day.

   C. Limit time for the client to perform activities.

   D. Talk the client through tasks one step at a time.

11. A nurse is providing discharge teaching to a client who has bipolar disorder and will be discharged with a prescription for lithium. The nurse should teach the client that which of the following factors puts her at risk for lithium toxicity?

   A. The client runs 4 miles outdoors every afternoon.

   B. The client drinks 2 liters of liquids daily.

   C. The client eats 2 to 3 gm of sodium-containing foods daily.

   D. The client eats foods high in tyramine.

12. A nurse is providing teaching for a client who has binge-eating disorder and is morbidly obese. The client has been prescribed orlistat. Which of the following statements indicates to the nurse that the client understands the teaching?

   A. "I will take my dose of orlistat every morning an hour before breakfast."

   B. "I will eat a no-fat diet to prevent side effects from the medication."

   C. "I will stop taking orlistat and call my doctor if my urine gets darker in color."

   D. "I will feel less hungry during meals while I am taking orlistat."

13. A nurse is caring for a client who has major depressive disorder and was prescribed citalopram 2 weeks ago with a planned dosage increase 1 week ago. The client reports having an improved appetite, but still feels very depressed and is still having trouble sleeping. Which of the following actions should the nurse take?

    A. Speak to the provider about adding an MAOI to the current medication regimen.

    B. Explain that antidepressants often take several weeks to be fully effective.

    C. Tell the client that the provider will need to change citalopram to a different medication.

    D. Recommend a sleep study be done on the client.

14. A nurse is caring for a client who was admitted with acute psychosis and is being treated with haloperidol. The nurse should suspect that the client may be experiencing tardive dyskinesia when the client exhibits which of the following? (Select all that apply.)

    A. Urinary retention and constipation

    B. Tongue thrusting and lip smacking

    C. Fine hand tremors and pill rolling

    D. Facial grimacing and eye blinking

    F. Involuntary pelvic rocking and hip thrusting movements

15. A nurse who works in a psychiatric unit is caring for a client who has bipolar disorder. The client comes to the nurse's station at 0300 demanding that the nurse call the provider immediately. Which of the following responses by the nurse is appropriate?

    A. "You are being unreasonable, and I will not call your doctor at this hour."

    B. "Go back to your room, and I'll try to get in touch with your doctor."

    C. "I can't call a doctor in the middle of the night unless it's an emergency."

    D. "You must be very upset about something."

16. A nurse caring for a client who has depression observes the client comes to breakfast freshly bathed, wearing clean clothes, and with combed and styled hair. Which of the following responses by the nurse is therapeutic?

    A. "Everyone feels better after showering."

    B. "You must be getting better. You look great!"

    C. "I see you have done some grooming today."

D. "Why are you all dressed up today? Is it a special occasion?"

17. A nurse is caring for a client who has schizophrenia and tells the nurse, "They lie about me all the time and they are trying to poison my food." Which of the following statements should the nurse make?

A. "You are mistaken. Nobody is lying about you or trying to poison you."

B. "You seem to be having very frightening thoughts."

C. "Why do you think you are being lied about and poisoned?"

D. "Who is lying about you and trying to poison you?"

18. A nurse is caring for a client who has been hospitalized for treatment of bipolar disorder and will be discharged with a prescription for lithium. The nurse's discharge teaching should include information cautioning against which of the following factors that may cause lithium toxicity?

A. Experiencing diarrhea

B. Exercising moderately

C. Increasing sodium intake

D. Drinking green tea

19. A nurse in an emergency department is caring for an adolescent client who reports being sexually assaulted just prior to admission. Which of the following actions should the nurse take?

A. Discuss self-defense techniques with the client.

B. Inform the client photographs of injuries are required for a police report.

C. Ask the client to describe the situation.

D. Give the client a bed bath prior to physical examination.

20. A nurse in an emergency department is assessing a client who has been taking haloperidol for 3 months. The client has a temperature of 39.5° C (103.4° F), blood pressure of 150/110 mm Hg, and muscle rigidity. Which of the following complications should the nurse suspect?

A. Agranulocytosis

B. Neuroleptic malignant syndrome

C. Akathisia

D. Tardive dyskinesia

21. A nurse in a mental health facility is planning care for a client who has obsessive-compulsive disorder (OCD) and is newly admitted to the unit. Which of the following actions should the nurse plan to take regarding the client's compulsive behaviors?

A. Isolate the client for a period of time.

B. Confront the client about the senseless nature of the repetitive behaviors.

C. Plan the client's schedule to allow time for rituals.

D. Set strict limits on the behaviors so that the client can conform to the unit rules and schedules.

22. A nurse in a psychiatric unit is caring for several clients. Which of the following clients should the nurse recommend for group therapy?

A. A client who has been taking amitriptyline for 3 months for depression

B. A client exhibiting psychotic behavior

C. A client admitted 12 hr ago for acute mania

D. A client who is experiencing alcohol intoxication

23. A nurse is planning care for a client newly admitted with major depressive disorder. Which of the following actions should the nurse plan to take?

A. Ask the client to create her own schedule of daily activities.

B. Teach the client to use passive communication when interacting with others.

C. Determine the client’s need for assistance with grooming.

D. Limit the client’s involvement in unit activities.

24. A nurse at a college campus mental health counseling center is caring for a student who just failed an examination. The student spends the session berating the teacher and the course. The nurse should recognize this behavior as which of the following defense mechanisms?

A. Conversion

B. Projection

C. Undoing

D. Regression

25. A nurse in a drug and alcohol detoxification center is planning care for a client who has alcohol use disorder. Which of the following interventions should the nurse identify as the priority?

A. Helping the client identify positive personality traits

B. Providing for adequate hydration and rest

C. Confronting the use of denial and other defense mechanisms

D. Educating the client about the consequences of alcohol misuse

26. A nurse is caring for a client who has bipolar disorder and is in the manic phase. The client says he is bored. Which of the following activities is appropriate for the nurse to suggest to this client?

A. Watching a video with a group in the day room

B. Walking with the nurse in the courtyard

C. Participating in a basketball game in the gym

D. Joining a group discussion about a local election

27. A nurse in a hospital is caring for a client who has agoraphobia. Which of the following statements by the client indicates understanding of the goals of treatment?

A. "I plan to sit on a park bench for a few minutes each day."

B. "I can try participating in group therapy every week."

C. "I will join a book club in my neighborhood."

D. "I should avoid entering elevators and other closed spaces."

28. A nurse asks a client who is suicidal to make a safety contract, but the client declines. Which of the following actions should the nurse identify as the priority?

A. Lock the doors to the unit and secure windows so they cannot be opened.

B. Provide the client with plastic eating utensils for meals.

C. Remove any objects from the client's environment that could be used for self-harm.

D. Assign a staff member to stay with the client at all times.

29. A nurse in an emergency department is assessing a client for suspected cocaine intoxication. Which of the following findings should the nurse expect?

    A. Nystagmus

    B. Dilated pupils

    C. Hypersomnia

    D. Depression

30. A nurse is caring for a client who is extremely suspicious of the nursing staff and other clients. Which of the following nursing approaches is appropriate when establishing a therapeutic relationship with this client?

    A. Disclose some personal information to the client to demonstrate approachability.

    B. Wait for the client to initiate interaction.

    C. Approach the client frequently throughout the day for brief interactions.

    D. Adopt a neutral attitude when providing care.

31. A nurse at a walk-in mental health clinic is assessing a client experiencing severe anxiety. The nurse should recognize the client might exhibit which of the following manifestations?

    A. Attention-seeking conduct

    B. Mild difficulty problem solving

    C. Mild fidgeting

    D. Threatening behavior

32. A nurse observes that a client who has depression is sitting alone in the room crying. As the nurse approaches, the client states, "I'm feeling really down and don't want to talk to anyone right now." Which of the following responses should the nurse make?

    A. "It might help you feel better if you talk about it."

    B. "I'll just sit here with you for a few minutes then."

    C. "I understand. I've felt like that before, too."

    D. "Why are you feeling so down?"

33. A nurse is caring for a client who has anorexia nervosa and overexercises to avoid gaining weight. Which of the following nursing actions should the nurse take?

    A. Praise the client for looking at herself in a mirror.

    B. Ask the client to agree to talk to a nurse whenever she feels the urge to exercise.

    C. Reprimand the client about the potential damage that has occurred due to overexercising her body.

    D. Restrict the client from being weighed.

34. A nurse is caring for a client who has a history of alcohol use disorder and has been hospitalized for detoxification. The nurse enters the room and finds the client shouting in a terrified voice, "Get these bugs off of me!" Which of the following responses by the nurse is appropriate?

    A. "I'm sure that the bugs you see will not harm you."

    B. "Tell me more about the bugs that you see in your room."

    C. "I don't see any bugs, but you seem very frightened."

    D. "I do not see anything. This is part of the withdrawal process."

35. A nurse is conducting a group therapy session for several clients. The group is laughing at a joke one of the clients told, when a client who is schizophrenic jumps up and runs out of the room yelling, "You are all making fun of me!" The nurse should identify this behavior as which of the following characteristics of schizophrenia?

    A. Magical thinking

    B. Delusions of grandeur

    C. Ideas of reference

    D. Looseness of association

36. A community health nurse is providing teaching to the family of a client who has primary dementia. Which of the following manifestations should the nurse tell the family to expect?

    A. Decreased auditory and visual acuity

    B. Decreased display of emotions

    C. Personality traits that are opposite of original traits

    D. Forgetfulness gradually progressing to disorientation

37. A male nurse is assigned to care for a female client who was admitted to the hospital for treatment of injuries following a domestic abuse incident. The client tells the nurse manager she does not want a male nurse as her caregiver. Which of the following nursing responses should the nurse manager make?

    A. "I can arrange for a female assistive personnel to do your personal hygiene care."

    B. "The nurse assigned to care for you is very capable and cares for other women in this situation."

    C. "Your doctor is a man, so it seems like this should not be a problem."

    D. "I can review the assignments and arrange for a female nurse to care for you."

38. A nurse in a psychiatric unit is admitting a client who attacked a neighbor. The nurse should know that the client can be kept in the hospital after the 72-hr hold is over for which of the following conditions?

    A. The client is a danger to herself or others.

    B. The client is unwilling to accept that treatment is needed.

    C. The client states that she does not like the neighbor.

    D. The client states that she plans to move out of the state immediately.

39. A nurse is caring for a client who has bipolar disorder and a new prescription for valproate. Which of the following instructions should the nurse give the client about the use of this medication?

    A. Thyroid function tests should be performed every 6 months.

    B. A pretreatment electroencephalogram (EEG) will be done.

    C. Liver function tests must be monitored.

    D. High serum sodium levels can cause toxic levels of valproate.

40. A nurse in an acute care mental health facility is preparing to administer morning medication for a client who has been taking lithium for 2 weeks and has a current lithium level of 1.0 mEq/L. Which of the following actions should the nurse take?

    A. Prepare for gastric lavage due to an extremely elevated lithium level.

    B. Administer the morning dose of lithium.

    C. Check the client's medication record to assess whether the client has been refusing her lithium.

    D. Hold the medication and assess for early manifestations of toxicity.

41. A nurse observes a client's spouse sitting alone in the waiting room crying. When approached, the spouse says, "I am really concerned about my husband." Which of the following is a therapeutic nursing response?

    A. "Your husband is making really good progress."

    B. "Crying helps us let things out and we feel better."

    C. "Did your husband say something to upset you?"

    D. "Tell me what is concerning you."

42. A nurse is caring for a client who is depressed and refuses to participate in group therapy or perform activities of daily living. Which of the following statements should the nurse make to the client?

    A. "I will assist you in getting out of bed and getting dressed."

    B. "You can remain in bed until you feel well enough to join the group."

    C. "The unit rules state that you may not remain in bed."

    D. "If you don't participate in your care, you will not get better."

43. A nurse is caring for a client who has borderline personality disorder (BPD). As part of the client's plan of care, the nurse reviews the day's schedule with the client each morning. As the nurse begins to review the schedule with the client, the client says, "Why don't you shut up already? I can read it myself, you know!" Which of the following responses should the nurse give the client?

    A. "We do this every day. Why are you so angry with me this morning?"

    B. "I don't like it when you address me with that tone of voice."

    C. "I know you can, but are you going to read it or not?"

    D. "Fine. Here is the schedule, and I will expect you to be on time to your therapies."

44. A nurse is caring for a client who has been diagnosed with obsessive compulsive disorder (OCD) and is constantly picking up after others in the day room. The nurse should recognize that the client uses this behavior to do which of the following?

    A. Limit the amount of time available to interact with others.

    B. Focus attention on meaningful tasks.

    C. Manipulate and control others' behaviors.

    D. Decrease anxiety to a tolerable level.

45. A nurse is assessing a parent who lost a 12-year-old child in a car crash 2 years ago. Which of the following findings indicates the client is exhibiting manifestations of prolonged grieving?

    A. Leaves the child's room exactly as it was before the loss

    B. Volunteers at a local children's hospital

    C. Talks about the child in the past tense

    D. Visits the child's grave every week after worship services

46. A nurse on a crisis hotline is speaking to a client who says, "I just took an entire bottle of amitriptyline." Which of the following responses should the nurse make?

    A. "I'm glad you called, and I want to send an ambulance to help you."

    B. "You must have been feeling pretty depressed to do that."

    C. "Do you know how many pills were in the bottle?"

    D. "Were you trying to kill yourself by taking an overdose?"

47. A nurse is caring for a client who has major depressive disorder and is scheduled for electroconvulsive therapy (ECT). The client's spouse asks the nurse about the possible side effects of the ECT. Which of the following responses should the nurse make?

    A. "The main side effects are temporary, and may include mild confusion, a headache, and short-term memory loss."

    B. "Most clients have no adverse effects to this treatment, but muscle cramping may result from the induced seizure."

    C. "Some clients have been known to have a myocardial infarction, but we will monitor your spouse closely to be certain this does not happen."

    D. "The most common side effects are directly related to the use of anesthesia."

48. A nurse is caring for a group of clients. The nurse should recognize that which of the following clients is at risk for a vitamin B6 deficiency?

    A. A client who takes gabapentin as part of treatment phenytoin for a seizure disorder.

    B. A client who has asthma.

    C. A client who has chronic alcohol use disorder.

D. A client who takes heparin to prevent deep vein thrombosis.

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49. A nurse is caring for an adolescent who is experiencing indications of depression. Which of the following findings should the nurse expect? (Select all that apply.)

A. Irritability

B. Euphoria

C. Insomnia

D. Low self-esteem

F. Chronic pain

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50. A nurse is caring for a hospitalized client who tells lies about other clients. The other clients on the unit frequently complain to the nursing staff about the client's disruptive behaviors. Which of the following initial actions should the nurse take?

A. Talk to the client and identify the specific limits that are required of the client's behavior.

B. Discuss the problem in a community meeting with the other clients on the unit present.

C. Escort the client to her room each time the nurse observes the client socializing with other clients.

D. Tell the other clients to ignore the client's lies.
