

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

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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."

**Rationale:** The nurse dismisses the client's concerns and gives false reassurance.

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

**Rationale:** The nurse is verbalizing the client's implied concerns and seeks to validate if this is the client's concern.

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

**Rationale:** The nurse assumes she understands the client's concerns and is promising something that may not be possible.

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

**Rationale:** The nurse assumes she understands the client's concerns and has a plan which may violate client confidentiality.

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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."

**Rationale:** This therapeutic response is an open-ended, empathetic statement that encourages the client to talk.

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

**Rationale:** This nontherapeutic response is focused inappropriately on the client's parents. It does not address the client's need to communicate or express feelings.

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

**Rationale:** This nontherapeutic response can make the client feel defensive, and he might not be able to tell the nurse why.

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

**Rationale:** This nontherapeutic response is a closed-ended statement that does not encourage the client to talk.

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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

**Rationale:**

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

A private room in a quiet location is ideal for a client with mania. The client may easily become overstimulated by the number of people and activities in a nursing care unit. A private room can be used for time-out during the day and to settle down to sleep at night.

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

**Rationale:** The client should not be given a semi-private room with a roommate who is also experiencing mania because the situation would be too stimulating for each of them.

- C. A private room close to the nursing station

**Rationale:** The client should not be given a private room close to the nursing station because of the high level of activity in that area.

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

**Rationale:** Legal and ethical guidelines require treatment in the least restrictive setting. Seclusion requires a provider's order and can only be used when there is a specific, documented need to do so.

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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.

**Rationale:** According to the nursing process, the nurse should perform an assessment first to gather enough data regarding nutritional status and other findings in order to plan, implement, and evaluate care. The assessment identifies client nutrition needs as well as complications the client might be experiencing related to the eating disorder.

- B. Request a mental health consult.

**Rationale:** Requesting a mental health consult might be necessary but another aspect of care is the priority.

- C. Plan a therapeutic diet for the client.

**Rationale:** Rationale C. Planning a therapeutic diet for the client will be necessary but another aspect of care is the priority.

- D. Provide a structured environment for the client.

**Rationale:** It is important to provide a structured environment for the client regarding meals, times for weighing, and monitoring of eating, but another aspect of care is the priority.

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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

**Rationale:** Cardiac dysrhythmias are a risk for clients taking haloperidol and other conventional

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

antipsychotic medications. The client should be monitored for changes in vital signs, tachycardia, and ECG changes, including prolonged QT interval, while taking haloperidol. There is a risk for cardiac arrest due to *torsades de pointes*.

B. Cataracts

**Rationale:** The client who takes haloperidol is at risk for glaucoma, but cataracts are not an adverse effect.

C. Pancreatitis

**Rationale:** The client who takes haloperidol is at risk for hepatitis, but pancreatitis is not an adverse effect.

D. Bleeding

**Rationale:** The client who takes haloperidol does not have an increased risk for bleeding.

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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."

**Rationale:** Trying to convince the client that his family members care about him is false reassurance that minimizes the feelings he just communicated.

B. "Why do you feel that way?"

**Rationale:** Asking the client a "why" question minimizes his feelings and is nontherapeutic.

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

**Rationale:** By asking the client to tell what people don't care about him, the nurse is challenging the client's beliefs and changing the focus of the client away from his feelings and onto another subject.

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

**Rationale:** This is an open-ended therapeutic statement that focuses on the client's feelings, shows empathy, and allows for further exploration of the client's belief that life is not worth living in order to keep the client safe from suicidal thoughts.

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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.

**Rationale:** The client is experiencing severe or panic-level anxiety and in this condition has difficulty comprehending instructions.

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

**Rationale:** Not intervening for the client's pacing and allowing it to continue could be a safety hazard for the

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

client and other clients in the area. The nurse should take measures to reduce the client's anxiety.

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

**Rationale:** The client is experiencing severe or panic-level anxiety and should not be left alone to rest.

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

**Rationale:** When the client is experiencing increased anxiety, it is important for the nurse to remain with the client and promote a calm atmosphere. By walking with the client at a gradually slowing pace, the nurse provides gross motor activity as an anxiety outlet that helps to calm the client and demonstrates therapeutic offering of self.

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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."

**Rationale:** This client is making a paranoid statement, something more typical of a client who has persecutory delusions. This statement is not characteristic of a client who has PTSD.

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

**Rationale:** This statement is not characteristic of a client who has PTSD.

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

**Rationale:** This client is making a grandiose statement, something more typical of a client who has bipolar disorder in the manic phase. This statement is not characteristic of a client who has PTSD.

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

**Rationale:** Many clients who have PTSD repeatedly re-experience the ordeal in the form of flashback episodes, memories, nightmares, or frightening thoughts, especially when they are exposed to events or objects reminiscent of the trauma. This client's statement about haunting dreams is typical of a client who has PTSD.

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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."

**Rationale:** The nurse should further explore this comment with the client but it does not indicate the greatest risk.

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

**Rationale:** There is a wide variation in maturation among adolescents, who often feel inferior if they are not maturing at the same pace as their peers. It is considered an expected finding for a 13-year-old

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

female to not have reached menarche. This comment should concern the nurse but it does not indicate the greatest risk to the client.

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

**Rationale:** This comment indicates the client might be at risk for depression, an eating disorder, or self-harm. Therefore, this comment is the priority for the nurse to address.

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

**Rationale:** The nurse should further explore this comment, as it might indicate the client has a problem with her body image. However, it does not indicate the greatest risk to the client. Young adolescents especially think that everyone is looking at them and seeing all their imperfections. It is difficult for them to learn to deal with this and can be a major crisis for them as they learn to deal with acceptance of themselves.

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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.

**Rationale:** The nurse should assign the same staff whenever possible to care for the client to minimize confusion and ensure continuity of care for the client.

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

**Rationale:** The nurse should provide a structured schedule of activities that does not change from day to day to decrease the client's confusion.

- C. Limit time for the client to perform activities.

**Rationale:** The nurse should allow plenty of time for the client to perform activities to increase comfort and decrease the client's anxiety level.

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

**Rationale:** The nurse should plan to talk the client through tasks one step at a time to minimize confusion and promote independence, which will decrease the client's anxiety level.

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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.

**Rationale:** Strenuous exercise in outdoor heat, which can lead to dehydration, puts the client at risk for lithium toxicity. Mild to moderate exercise will not lead to lithium toxicity, but if the client engages in strenuous exercise during hot weather, she should take care to replace any water and sodium that have been lost through profuse sweating. This also applies to other factors that can cause the client to become dehydrated, such as having diarrhea or taking diuretics.

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

B. The client drinks 2 liters of liquids daily.

**Rationale:** Drinking 2 to 3 L of liquid daily can help prevent lithium toxicity by promoting normal excretion of lithium from the body.

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

**Rationale:** Although 2 to 3 gm of sodium-containing foods is above recommended nutrition guidelines, this amount of sodium does not put the client at risk for lithium toxicity. Eating a diet with consistent and adequate amounts of sodium is important for a client who takes lithium. A very low-sodium diet prevents normal excretion of lithium from the body and can cause lithium toxicity. A high sodium intake will lead to excretion of lithium and a possible drop in lithium level. The client should be taught to eat an adequate, stable amount of sodium and not to greatly decrease or increase sodium intake.

D. The client eats foods high in tyramine.

**Rationale:** Foods high in tyramine interact with monoamine oxidase inhibitors which are prescribed for depressive disorders. Tyramine does not affect lithium levels.

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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."

**Rationale:** Orlistat, a lipase inhibitor, is used as an aid to help clients who are morbidly obese to lose weight. Orlistat prevents the absorption of some of the fat in the client's dietary intake at each meal. Therefore, the client should take the medication 3 times daily, during or within 1 hr after the meal.

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

**Rationale:** Consuming too little fat may lead to the client not getting enough nutrients, especially fat-soluble vitamins, from the diet. Instead, the client should eat a well-balanced, low-calorie, nutritious diet with approximately 30% of calories consisting of fat calories.

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

**Rationale:** Orlistat can cause severe liver damage; therefore, the client should be taught manifestations of liver damage, including dark-colored urine, light-colored stools, jaundice, anorexia, vomiting, and fatigue.

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

**Rationale:** Orlistat works by preventing absorption of dietary fat and is not an appetite suppressant.

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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?

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

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

**Rationale:** Giving a SSRI along with an MAOI is contraindicated due to a greatly increased risk for serotonin syndrome.

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

**Rationale:** SSRIs are used along with certain anticonvulsant medications in the treatment of bipolar disorder. It can take 4 to 6 weeks before therapeutic effects occur after beginning an antidepressant medication.

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

**Rationale:** It would be inappropriate for the nurse to tell the client that citalopram needs to be changed to a different prescription. The nurse should teach the client about expected effects of citalopram.

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

**Rationale:** Recommending a sleep study is not appropriate at this time until therapeutic effects of the medication are known. The nurse should teach the client about expected effects of citalopram.

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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

**Rationale:** Urinary retention and constipation is incorrect. Haloperidol can cause anticholinergic effects, such as dry mucous membranes, urinary retention, and constipation. However, these are not manifestations of tardive dyskinesia. Tongue thrusting and lip smacking is correct. Individuals who have tardive dyskinesia make repetitive and uncontrollable movements such as tongue thrusting and lip smacking. Fine hand tremors and pill rolling is incorrect. The side effects of haloperidol can include extrapyramidal (parkinsonian) symptoms, such as fine hand tremors and pill rolling. However, these are not manifestations of tardive dyskinesia. Facial grimacing and eye blinking is correct. Individuals who have tardive dyskinesia make repetitive and uncontrollable movements such as facial grimacing and eye blinking. Involuntary pelvic rocking and hip thrusting movements is correct. Repetitive, irregular, and involuntary movements of the head, neck, trunk, and extremities can occur in tardive dyskinesia.

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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?

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

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

**Rationale:** This response by the nurse shows disapproval and is therefore nontherapeutic.

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

**Rationale:** This response puts the client's feelings on hold and is therefore nontherapeutic.

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

**Rationale:** This response by the nurse puts the client's feelings on hold and is therefore nontherapeutic.

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

**Rationale:** This therapeutic response allows the nurse to show empathy for the client's feelings. The response is also open-ended, which allows for further communication and encourages the client to clarify the situation.

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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."

**Rationale:** This response is nontherapeutic because it involves stereotyping.

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

**Rationale:** This response is nontherapeutic because it makes assumptions about the client and shows approval.

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

**Rationale:** This response is open-ended, and this response is therapeutic because it offers the client recognition of positive behavior and encourages further discussion.

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

**Rationale:** This response is nontherapeutic because asking "why" questions can cause the client to feel defensive.

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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."

**Rationale:** This statement is a nontherapeutic response because it directly contradicts the client's delusional thinking, which could make the client feel angry and misunderstood.

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

**Rationale:** When responding to a client who is delusional, the nurse should avoid making statements that

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

directly confront or affirm the client's delusional beliefs. Instead of responding literally to the client's words, the nurse should respond to the feelings that the client is attempting to communicate. By doing this, the nurse is shifting the focus from the delusional beliefs, which are not real, to the client's fear, which is real.

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

**Rationale:** This statement is a nontherapeutic response because it supports the content of the client's delusional thinking. Asking a client "why" can cause the client to become defensive.

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

**Rationale:** This statement is a nontherapeutic response because it supports the content of the client's delusional thinking.

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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

**Rationale:** Lithium is used to treat the manic stage of bipolar disorder. Toxicity occurs when the level of lithium in the blood becomes too high. A low sodium level, or factors which result in a low sodium level, (such as dehydration, diarrhea, sweating, excess exercise in hot weather, diuretic use, a low sodium diet) increases the lithium level because the kidney processes sodium and lithium in the same way. If sodium levels fall, the body conserves lithium, causing lithium levels to rise.

- B. Exercising moderately

**Rationale:** Moderate exercise should not lead to lithium toxicity.

- C. Increasing sodium intake

**Rationale:** Increasing sodium intake will lead to excretion of lithium and a drop in the lithium level.

- D. Drinking green tea

**Rationale:** Both green and black tea can lower lithium levels, making it less effective.

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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.

**Rationale:** During the acute phase following sexual assault, the nurse should avoid implying the client could have done something different, which could cause the client to assume guilt for the situation.

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

**Rationale:**

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

The nurse should encourage the client to allow photographs of injuries as evidence to include in a police report, but it is not required. The nurse must obtain client consent before taking photographs.

- C. Ask the client to describe the situation.

**Rationale:** During the acute phase following assault, the nurse should encourage the client to provide information which may be helpful with treatment and to reduce the client's anxiety.

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

**Rationale:** The nurse should check the client for acute injuries that require medical attention. The nurse can offer to assist the client with a bath or shower after physical examination and collection of evidence.

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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

**Rationale:** The nurse should suspect agranulocytosis if a client reports flu-like manifestations and has a decreased white blood cell count.

- B. Neuroleptic malignant syndrome

**Rationale:** Neuroleptic malignant syndrome (NMS) is a rare and potentially fatal adverse effect of antipsychotic medications that requires emergency medical intervention. Manifestations of NMS are sudden and include changes in level of consciousness, seizures, and stupor.

- C. Akathisia

**Rationale:** The nurse should suspect akathisia if the client exhibits motor restlessness, such as foot tapping or constantly shifting weight back and forth.

- D. Tardive dyskinesia

**Rationale:** The nurse should suspect tardive dyskinesia if the client exhibits involuntary muscular movements.

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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.

**Rationale:** Because OCD is an anxiety disorder, the nurse should offer presence, and take action to help the client feel safe and secure.

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

**Rationale:**

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

The nurse should assist the client in identifying the meaning behind his behaviors to help the client change his actions.

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

**Rationale:** OCD is an anxiety disorder characterized by recurrent patterns of behavior a client feels driven to perform. This behavior can be a physical action or a mental act that is aimed at neutralizing anxiety or distress. In the initial phase of treatment, the nurse should allow adequate time for the client to perform rituals to help the client handle anxiety.

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

**Rationale:** The nurse should provide a structured, flexible environment initially, and gradually increase limits on client behavior as the client's anxiety becomes more manageable.

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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

**Rationale:** Psychotherapy groups provide clients with the opportunity to enhance their personal relationships, increase self-awareness, and try new behaviors in a safe social setting. Amitriptyline can take 4 to 8 weeks to become effective; therefore, this client should be experiencing improvement in depressive manifestations and be ready to interact in a group setting.

- B. A client exhibiting psychotic behavior

**Rationale:** The nurse should not recommend this client for group therapy until the psychosis resolves.

- C. A client admitted 12 hr ago for acute mania

**Rationale:** The nurse should not plan to include this client in group therapy until the client can interact appropriately with others.

- D. A client who is experiencing alcohol intoxication

**Rationale:** The nurse should not plan to include this client in group therapy until the intoxication resolves.

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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.

**Rationale:** The nurse should expect a client who has major depressive disorder to have difficulty making decisions.

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

**Rationale:** The nurse should encourage the client to use assertiveness techniques to increase self-esteem.

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

- C. Determine the client's need for assistance with grooming.

**Rationale:** The nurse should promote problem-solving by helping the client identify situations which can or cannot be controlled. This can help the client deal with unresolved issues.

- D. Limit the client's involvement in unit activities.

**Rationale:** The nurse should recognize the client will want to spend most of her time alone; the nurse should encourage interaction with groups to increase her self-esteem.

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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

**Rationale:** The nurse should identify conversion as a defense mechanism in which the client unconsciously expresses emotional conflict via physical symptoms, such as paralysis or loss of sensory function.

- B. Projection

**Rationale:** Projection is a defense mechanism in which the client refuses to acknowledge unacceptable personal characteristics and transfers feelings, thoughts, or traits onto another person. Instead of dealing with his own failures, the client is describing the shortcomings of the course and teacher.

- C. Undoing

**Rationale:** The nurse should identify undoing as a defense mechanism in which the client takes an action to make up for a wrong action or statement.

- D. Regression

**Rationale:** The nurse should identify regression as a defense mechanism in which the client adopts a more primitive, immature behavior in response to an unwanted situation.

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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

**Rationale:** Assessment of coping skills is important, but it is not the primary focus of care during the early phase of alcohol withdrawal.

- B. Providing for adequate hydration and rest

**Rationale:** Providing for the client's physical needs should be the nurse's priority until the client completes the detoxification phase of treatment. Rest is important for two reasons: alcohol use disrupts normal sleep patterns, and alcohol withdrawal or detoxification is often associated with increased restlessness and agitation. Restoring and maintaining fluid and electrolyte balance is

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

another important goal during detoxification to prevent fluid and electrolyte imbalances.

- C. Confronting the use of denial and other defense mechanisms

**Rationale:** The nurse should help the client admit a problem, but this is not the primary focus of care during the early phase of alcohol withdrawal.

- D. Educating the client about the consequences of alcohol misuse

**Rationale:** The nurse should help the client understand consequences, but this is not the primary focus of care during the early phase of alcohol withdrawal.

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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

**Rationale:** The nurse should limit the client's exposure to groups and crowds because it can increase the client's hyperactivity.

- B. Walking with the nurse in the courtyard

**Rationale:** Clients who have bipolar disorder are prone to hyperactivity. The nurse should provide activities that provide a way for the client to release physical energy, while avoiding situations that might provoke the client. In addition, walking with the nurse provides an opportunity for therapeutic communication.

- C. Participating in a basketball game in the gym

**Rationale:** The nurse should not encourage the client to participate in competitive games because it can increase the client's hyperactivity.

- D. Joining a group discussion about a local election

**Rationale:** The nurse should limit the client's exposure to groups and crowds because it can increase the client's hyperactivity.

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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."

**Rationale:** Agoraphobia is fear of being in places in which help may not be available. This typically manifests as a fear of being outside alone. Therefore, the nurse should identify this statement as understanding of the goals of treatment.

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

**Rationale:** The client's phobia does not concern exposure to other people.

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

**Rationale:**

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

The client's phobia does not concern exposure to other people.

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

**Rationale:** The client's phobia does not concern exposure to other people.

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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.

**Rationale:** The nurses should lock the doors and windows on the unit so the client cannot leave the unit, or obtain objects for inflicting self-harm; however, the nurse should identify another action as the priority.

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

**Rationale:** The nurse should provide the client with plastic eating utensils to avoid providing the client with an object for inflicting self-harm; however, the nurse should identify another action as the priority.

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

**Rationale:** The nurse should remove objects from the environment that could be used for self-harm. Additionally, the nurses should check the client's belongings, and prevent visitors from bringing in harmful objects; however, the nurse should identify another action as the priority.

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

**Rationale:** The greatest risk to this client is self-injury during unsupervised time; therefore, the nurse should identify the priority action is to assign a staff member to stay with the client at all times. The staff member can monitor all of the client's behaviors and actions and prevent the client from harming herself.

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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

**Rationale:** Nystagmus, a rapid involuntary oscillation of the eyeballs, is not associated with cocaine intoxication. The client can experience perspiration and tremors.

- B. Dilated pupils

**Rationale:** Dilated pupils are a finding of cocaine intoxication due to the stimulation of the sympathetic nervous system.

- C. Hypersomnia

**Rationale:** The nurse should expect the client to exhibit hypervigilance and have increased energy.

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

D. Depression

**Rationale:** The nurse should expect the client to exhibit euphoria and grandiosity.

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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.

**Rationale:** The nurse should provide the client with general leads and maintain the boundaries of a professional therapeutic relationship with the client rather than a social relationship.

B. Wait for the client to initiate interaction.

**Rationale:** The nurse should initiate interaction with the client to show interest in the client's needs and to establish rapport.

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

**Rationale:** The nurse should avoid appearing too friendly, but should use a straightforward attitude during care and communication.

D. Adopt a neutral attitude when providing care.

**Rationale:** To promote a therapeutic relationship, the nurse should use a neutral, nonthreatening attitude during care and communication.

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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

**Rationale:** The nurse should expect a client experiencing severe anxiety to exhibit purposeless behavior.

B. Mild difficulty problem solving

**Rationale:** The nurse should expect a client experiencing severe anxiety to report that problem solving seems impossible.

C. Mild fidgeting

**Rationale:** When experiencing severe anxiety, the client's perceptual field is scattered and the client is not able to focus on anything except relieving the anxiety.

D. Threatening behavior

**Rationale:** The client experiencing severe anxiety can have feelings of confusion and impending doom. The client may feel the need to be aggressive and defensive, speaking with loud, rapid speech and possibly making threats and demands of others.

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## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

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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."

**Rationale:** This response by the nurse provides false reassurance, and is therefore nontherapeutic.

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

**Rationale:** This therapeutic response is an example of offering self. By sitting with the client, the nurse demonstrates caring and concern, and shows the client that the nurse is available if the client wants to talk.

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

**Rationale:** This response by the nurse shows approval or agreement. It is nontherapeutic response because it implies that not communicating is the right thing to do, and could cause the client to focus on the approval of the staff instead of making her own choices.

D. "Why are you feeling so down?"

**Rationale:** This response includes a "why" statement, which could cause the client to feel defensive. Therefore, this statement is nontherapeutic.

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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.

**Rationale:** A client who has anorexia nervosa monitors weight and appearance excessively, but does not have a proper body image. The nurse should avoid sounding too complimentary of the client's appearance because it may reinforce negative thoughts.

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

**Rationale:** To promote effectiveness of treatment, the nurse should implement actions which establish trust and partnership with the client. This action should help the client view the nurse as a partner in treatment.

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

**Rationale:** The nurse should focus teaching on healthy eating and addressing wrong thoughts about weight gain. Confronting the client is not likely to be effective until the client can resolve the issues that underlie the behaviors associated with anorexia nervosa.

D. Restrict the client from being weighed.

**Rationale:** During therapy, the nurse should weigh the client daily for the first week, then three times a week. A client who has anorexia nervosa is likely to want to avoid weighing or seeing the weight.

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## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

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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."

**Rationale:** The nurse should avoid talking about the hallucinations as though they are true.

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

**Rationale:** The nurse should avoid talking about the hallucinations as though they are true.

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

**Rationale:** This client is experiencing a tactile hallucination, which is common during alcohol withdrawal. This response by the nurse presents reality and shows empathy by acknowledging the client's feelings.

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

**Rationale:** The nurse should not argue with what the client is experiencing, as the hallucinations are very real to the client.

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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

**Rationale:** The nurse should recognize that magical thinking occurs when a client believes his actions or thoughts can magically make things happen.

B. Delusions of grandeur

**Rationale:** The nurse should recognize that delusions of grandeur occur when a client attaches special significance to his self-stature and has a drastically exaggerated sense of self-importance.

C. Ideas of reference

**Rationale:** When ideas of reference are present, the client believes all events, situations, or interactions are directly related to him.

D. Looseness of association

**Rationale:** The nurse should recognize associate looseness occurs when the client's verbal communication jumps from one unrelated topic to another. The client is often unaware he is not making sense.

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36. A community health nurse is providing teaching to the family of a client who has primary dementia. Which of the

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

following manifestations should the nurse tell the family to expect?

- A. Decreased auditory and visual acuity

**Rationale:** Dementia is not known to affect auditory and visual senses. The nurse should instruct the family to expect the client's reasoning and logic skills to decline.

- B. Decreased display of emotions

**Rationale:** The nurse should tell the family to expect the client to be unable to control emotions and behavior, and be more likely to exhibit emotional outbursts.

- C. Personality traits that are opposite of original traits

**Rationale:** The nurse should instruct the family to expect the client to demonstrate an exaggeration of previous personality traits.

- D. Forgetfulness gradually progressing to disorientation

**Rationale:** Dementia usually appears first as forgetfulness. Other manifestations may be apparent only upon neurologic examination or cognitive testing. Loss of functioning progresses slowly from impaired language skills and difficulty with ordinary daily activities to severe memory loss and complete disorientation with withdrawal from social interaction.

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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."

**Rationale:** This is not a therapeutic response to the client's needs. It does not address the client's fear of being cared for by a male.

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

**Rationale:** In this nontherapeutic response, the nurse blocks further communication with the client by being defensive.

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

**Rationale:** In this nontherapeutic response, the nurse blocks further communication by ignoring the client's concerns.

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

**Rationale:** In this therapeutic response, the nurse demonstrates empathy by endeavoring to meet the client's request for a female caregiver.

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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?

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

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

**Rationale:** The criteria for involuntary admission includes that the client has a mental disorder that will likely result in serious bodily harm to self or another person, unless the client remains in a psychiatric facility.

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

**Rationale:** This is not sufficient grounds for detaining the client once the involuntary hold has expired.

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

**Rationale:** This is not sufficient grounds for detaining the client once the involuntary hold has expired.

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

**Rationale:** This is not sufficient grounds for detaining the client once the involuntary hold has expired

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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.

**Rationale:** Hypothyroidism is a long-term risk for clients who take lithium, not valproate.

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

**Rationale:** An EEG is a test that examines brain waves and is used for clients who have a seizure disorder. Although valproate is used as an anticonvulsant in some clients, an EEG is not necessary because this client is using valproate as a mood stabilizer for bipolar disorder, not as an anticonvulsant.

- C. Liver function tests must be monitored.

**Rationale:** Pancreatitis, hepatic dysfunction, and thrombocytopenia are serious adverse effects occasionally associated with valproate. Liver function tests should be monitored periodically to check for hepatic failure.

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

**Rationale:** Low serum sodium levels affect lithium levels, but serum sodium does not affect blood levels of valproate.

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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.

**Rationale:** Based on the client's current lithium level, preparing for gastric lavage is not the correct nursing action.

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

- B. Administer the morning dose of lithium.

**Rationale:** The nurse should administer the lithium dose since a lithium level of 1.0 mEq/L is within the expected initial therapeutic range of 0.8 to 1.3 mEq/L. At a therapeutic level the client might demonstrate adverse effects of lithium, such as a fine hand tremor, thirst, and mild nausea, and the nurse should note if any of these manifestations are present. The nurse should continue to monitor for adverse effects and signs of toxicity, which usually occur at levels of 1.5 mEq/L or higher.

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

**Rationale:** Based on the client's current lithium level, checking the medication record to assess whether the client has been refusing lithium is not the correct nursing action.

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

**Rationale:** Based on the client's current lithium level, holding the medication and assessing for early manifestations of toxicity is not the correct action.

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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."

**Rationale:** This nontherapeutic response uses the communication block of focusing on an inappropriate person (the spouse).. It negates the spouse's concerns.

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

**Rationale:** This non-therapeutic response makes a statement about what the nurse believes, but does not encourage communication about the spouse's concerns.

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

**Rationale:** This nontherapeutic response uses the communication block of focusing on an inappropriate person and is a closed-end question.

- D. "Tell me what is concerning you."

**Rationale:** This therapeutic response uses the communication tool of clarification. This response encourages further communication and expression of feelings.

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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."

**Rationale:** Severely depressed persons have problems with self-care and are easily overwhelmed. A nursing approach that focuses on meeting the client's physiologic and basic needs directly is best. The presence of the nurse conveys that the client is worthy of the nurse's attention and will help the client adjust to the hospitalization.

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

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

**Rationale:** This nontherapeutic approach uses the communication block of ignoring the client's basic needs.

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

**Rationale:** This nontherapeutic approach uses the communication block of focusing on the rules instead of the client.

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

**Rationale:** This nontherapeutic approach uses the communication block of threatening the client.

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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?"

**Rationale:** This nontherapeutic response is defensive and also expects an anxious client to answer an introspective question. Asking a client "why" is rarely a correct response. More importantly, it does not call to the client's attention the inappropriate behavior and set appropriate limits for further communication.

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

**Rationale:** BPD is described as an emotionally unstable personality. Clients who have BPD might show a wide range of impulsive behaviors in all aspects of their lives, including self-destructive behaviors. The client in this situation has overstepped a limit by addressing the nurse in a less-than-respectful tone of voice. This therapeutic response calls to the client's attention the inappropriate behavior and sets appropriate limits for further communication. This is the best approach to continue communication with this client.

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

**Rationale:** This nontherapeutic response is a closed-ended question that challenges the client. More importantly, it does not call to the client's attention the inappropriate behavior and set appropriate limits for further communication.

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

**Rationale:** This nontherapeutic response is a closed-ended statement that challenges the client. More importantly, it does not call to the client's attention the inappropriate behavior and set appropriate limits for further communication.

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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?

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

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

**Rationale:** This is not the etiology of OCD behaviors.

B. Focus attention on meaningful tasks.

**Rationale:** The repetitive rituals most commonly involve meaningless tasks.

C. Manipulate and control others' behaviors.

**Rationale:** Clients whose behavior pattern seeks to control or manipulate others are clients with personality disorders such as borderline, antisocial, histrionic, or passive-aggressive personality disorders.

D. Decrease anxiety to a tolerable level.

**Rationale:** With OCD, obsessions give rise to anxiety, and the anxiety is then reduced by compulsive behaviors. Compulsive rituals are strengthened and maintained because they decrease the anxiety by terminating the event that gives rise to it.

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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

**Rationale:** Grieving becomes dysfunctional when the client is unable to resume regular activities of daily living or experience emotions other than sadness or depression. An example of dysfunctional grieving is making the loved one's room a shrine for more than a year.

B. Volunteers at a local children's hospital

**Rationale:** The ability to resume normal activities of daily living is an important step in the resolution of the grieving process. Volunteering at a children's hospital shows that the client is resuming normal activities of daily living and is able to give to others.

C. Talks about the child in the past tense

**Rationale:** Talking about the child in the past tense is considered an appropriate act of eulogizing the child.

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

**Rationale:** Visiting the child's grave weekly is considered an appropriate remembrance of the child.

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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."

**Rationale:** Amitriptyline, a tricyclic antidepressant, is used to treat depression. This therapeutic statement shows the nurse's concern for the client's safety and responds to the client's priority need.

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

Maslow's hierarchy of needs states that the client's physical and safety needs come first. Therefore, the client needs to be evaluated immediately.

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

**Rationale:** This client is in immediate danger. Therefore, this is a nontherapeutic statement and is not appropriate for the nurse to state.

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

**Rationale:** This client is in immediate danger. Therefore, this is a nontherapeutic statement and is not appropriate for the nurse to state.

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

**Rationale:** This client is in immediate danger. Therefore, this is a nontherapeutic statement and is not appropriate for the nurse to state.

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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."

**Rationale:** The main side effects are mild disorientation and confusion immediately after the treatment, a slight headache, and short-term memory problems.

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

**Rationale:** Muscle cramping is not a side effect of ECT. Before receiving the treatment, the client is medicated with a muscle relaxant to prevent any muscle contractions during the brain 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."

**Rationale:** Myocardial infarction is not an expected side effect of ECT therapy.

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

**Rationale:** There are other temporary adverse effects associated with the ECT itself.

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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.

**Rationale:** Neither epilepsy nor oral anticonvulsant therapy increases a client's risk for B<sub>6</sub> deficiency. The nurse should recognize gabapentin could cause increased appetite and weight gain.

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

B. A client who has asthma.

**Rationale:** The nurses should not expect a client who has asthma to be at risk for vitamin deficiencies.

C. A client who has chronic alcohol use disorder.

**Rationale:** The nurse should recognize that alcohol consumption destroys and increases elimination of vitamin B<sub>6</sub> from the body; therefore, this client is at risk for vitamin B<sub>6</sub> deficiency.

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

**Rationale:** The nurse should recognize heparin does not cause a vitamin B<sub>6</sub> deficiency, but can cause thrombocytopenia.

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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

**Rationale:** Depressed teens are often irritable, taking out much of their anger on their friends and family. Signs include being critical, sarcastic, or abusive, and appearing restless, agitated, and angry. Euphoria, or a feeling of well-being or elation, is not associated with depression; it is associated with the manic phase of bipolar disorder. Insomnia (too little sleep) and hypersomnia (too much sleep) are two sleep pattern disturbances that may be associated with depression. A depressed teen may also complain of chronic or persistent fatigue, regardless of the amount of sleep they get. Low self-esteem is one of the most common causes of teen depression. Teens who have trouble in school are at a higher risk for depression than kids who do well in school. Somatic, or physical, symptoms of depression are common in teens. Chronic pain that is not caused by physical disease most often includes headaches and stomachaches.

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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.

**Rationale:** Discussing the problem behaviors with the client and informing her of which behaviors cannot be done on the unit is therapeutic communication.

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

**Rationale:** This is not appropriate, as there is no need for other clients on the unit to be involved.

## Detailed Answer Key LVN-RN Mental Health NCLEX Practice

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

**Rationale:** Preventing the client from interacting with others on the unit will isolate the client and tend to encourage further inappropriate behaviors.

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

**Rationale:** Telling the other clients to ignore the behavior does nothing to solve the problem and does not help their feelings of the other clients.

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