LIPPINCOTT MOOD DISORDERS PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. **What is the length of time for which the effects of SSRIs are typically fully realized?**

   A. 1 to 2 weeks.

   B. 2 to 4 weeks.

   C. 6 to 8 weeks.

   D. Immediately.

2. **Which transient adverse effect of fluoxetine (Prozac) requires immediate action from the nurse?**

   A. Nausea.

   B. Dizziness.

   C. Sedation.

   D. Dry mouth.

3. **What is the appropriate amount of medication to provide an outpatient client treated with imipramine for recurrent depression?**

   A. 30-day supply

   B. 21-day supply

   C. 14-day supply

   D. 7-day supply

4. **A client is scheduled for ECT and refuses a sleep medication. How should the nurse prioritize care?**

   A. Encourage the use of Restoril.

   B. Offer use of MP3 player with relaxing music.

   C. Discuss specific concerns.

   D. Sit quietly with the client.

5. **What should a nurse reassure a client at risk of suicide regarding their feelings?**

   A. They should not take their feelings too seriously

   B. Many people feel that way but don't act on it

   C. It is important to discuss these feelings and thoughts openly

   D. They will feel better eventually without intervention

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6. If a client with acute mania is continuously talking during lunchtime, how should the nurse respond?

A. Tell the client to stop talking and eat

B. Excuse themselves while guiding the client to lunchtime

C. Wait for the client to finish talking

D. Walk away and return later

7. What is an important aspect of discharge planning for a client with a history of suicidal ideation?

A. Assessing the client's living situation for safety

B. Providing detailed therapy notes and records

C. Encouraging the client to minimize stressful interactions

D. Advocating for voluntary hospitalization only

8. Which food should a client taking phenelzine (Nardil) avoid?

A. Roasted chicken.

B. Salami.

C. Fresh fish.

D. Hamburger.

9. When developing a care plan for a client with suicidal ideation, what should the nurse prioritize?

A. Self-esteem

B. Sleep

C. Hygiene

D. Safety

10. What should a nurse do first when a client on phenelzine reports a throbbing headache?

A. Give the client an analgesic prescribed PRN.

B. Call the primary health care provider to report the symptom.

C. Administer the client's next dose of phenelzine.

D. Obtain the client's vital signs.

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Answers

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1. B
2. B
3. D
4. D
5. C
6. B
7. A
8. B
9. D
10. D

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Explanations

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1. What is the length of time for which the effects of SSRIs are typically fully realized?

A. 1 to 2 weeks.

B. 2 to 4 weeks.

C. 6 to 8 weeks.

D. Immediately.

The typical timeframe for the effects of SSRIs (Selective Serotonin Reuptake Inhibitors) to be fully realized is generally around 2 to 4 weeks. While some individuals may start to notice improvements in their symptoms within the first week or so, the full therapeutic effects are often not evident until the 2 to 4-week mark. This delay is attributed to the time it takes for the medications to alter neurotransmitter levels in the brain and for the body to adapt to these changes, leading to significant mood improvements. In the context of the other options, the immediate effect suggested would imply that the medication has an instant impact, which is not reflective of how SSRIs operate. Shorter timeframes such as 1 to 2 weeks are also insufficient for the full benefits to manifest, as the gradual buildup of serotonin levels and the brain's response to the medication takes longer. Consequently, the 2 to 4 weeks timeframe appropriately captures the expected period in which patients may start to experience the full benefits of SSRIs.

2. Which transient adverse effect of fluoxetine (Prozac) requires immediate action from the nurse?

A. Nausea.

B. Dizziness.

C. Sedation.

D. Dry mouth.

In the context of fluoxetine (Prozac), dizziness is a transient adverse effect that can indicate a more serious underlying issue, especially if it is sudden or severe. While nausea, sedation, and dry mouth are common and usually less alarming side effects, dizziness may lead to falls or injuries if it causes instability in the patient. Dizziness can also be associated with conditions such as orthostatic hypotension, which warrants immediate intervention to ensure the patient's safety. Immediate action from the nurse may include assessing the patient's vital signs, determining the potential for falls, and evaluating if any supportive measures or adjustments in medication are necessary. Thus, recognizing dizziness as a potentially more concerning effect prompts appropriate and timely nursing interventions.

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3. What is the appropriate amount of medication to provide an outpatient client treated with imipramine for recurrent depression?

A. 30-day supply

B. 21-day supply

C. 14-day supply

D. 7-day supply

When prescribing medications for an outpatient client treated with imipramine for recurrent depression, safety and supervision are paramount. Imipramine is a tricyclic antidepressant that can have serious side effects and carries a risk of overdose, especially in patients with a history of depression. Therefore, providing only a limited supply of medication, such as a 7-day supply, allows the healthcare provider to closely monitor the patient for any adverse effects or complications related to the medication. This short supply also encourages regular follow-ups, ensuring that the client is managing their condition effectively and is responding appropriately to the medication. If the patient demonstrates stability and a good response to treatment over time, the provider may consider increasing the supply during subsequent visits, but starting with a limited amount is a standard practice to ensure patient safety.

4. A client is scheduled for ECT and refuses a sleep medication. How should the nurse prioritize care?

A. Encourage the use of Restoril.

B. Offer use of MP3 player with relaxing music.

C. Discuss specific concerns.

D. Sit quietly with the client.

In this scenario, the priority of care revolves around providing emotional support and ensuring the client feels heard and understood. Sitting quietly with the client serves as a crucial method for building trust and rapport, especially if the client is feeling anxious or resistant to the treatment plan. By simply being present, the nurse creates a safe and supportive environment, allowing the client to express feelings or concerns about their care. This approach emphasizes the importance of the therapeutic relationship in nursing practice, which is foundational in mental health care. Other methods may also offer relaxation or distraction, such as using music or discussing concerns, but the act of sitting quietly emphasizes validation and companionship. It can ultimately pave the way for further dialogue regarding the refusal of medication and facilitate a more in-depth conversation about the client's thoughts and feelings. Prioritizing emotional support in this way can enhance the client's sense of security, making them more open to discussing their options and receiving care.

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5. What should a nurse reassure a client at risk of suicide regarding their feelings?

A. They should not take their feelings too seriously

B. Many people feel that way but don't act on it

C. It is important to discuss these feelings and thoughts openly

D. They will feel better eventually without intervention

Reassuring a client at risk of suicide regarding their feelings is crucial for providing support and fostering a therapeutic relationship. Emphasizing the importance of discussing their feelings and thoughts openly helps validate their experiences and encourages them to express their emotions. This openness is essential for safety because it allows caregivers and clinicians to understand the client's mindset better, assess the level of risk, and create a supportive environment aimed at effective intervention. By advocating for open discussion, the nurse helps dismantle any stigma the client might feel about their emotions, reinforcing that it's okay to have difficult feelings and that sharing them is a step toward healing. This approach also facilitates safety planning and can lead to strategies that the client can employ to cope with their feelings in a healthier way. The other options are less appropriate as they either minimize the client's feelings, suggest passivity in dealing with those feelings, or imply that feelings alone can be ignored without intervention.

6. If a client with acute mania is continuously talking during lunchtime, how should the nurse respond?

A. Tell the client to stop talking and eat

B. Excuse themselves while guiding the client to lunchtime

C. Wait for the client to finish talking

D. Walk away and return later

In the context of managing a client with acute mania, the nurse's response should prioritize effective communication and safety. Guiding the client to lunchtime while excusing themselves provides a supportive structure. This approach acknowledges the client's need for expression while also gently redirecting them to an appropriate activity—eating lunch. By choosing to lead the client to lunchtime, the nurse maintains the therapeutic relationship without being confrontational or dismissive. This action helps the client engage in necessary self-care activities, such as eating, which can often be neglected during manic episodes. It also ensures the nurse remains present to monitor the client's well-being while establishing boundaries in a calm and structured manner. This response is beneficial in a therapeutic setting, where the goal is to manage the symptoms of mania while fostering an environment that encourages the client to participate in normal daily routines. The other options either risk alienating the client or do not adequately address the situation's needs, such as allowing the client to continue excessively talking without guidance or walking away, both of which could exacerbate feelings of instability in the client.

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7. What is an important aspect of discharge planning for a client with a history of suicidal ideation?

A. Assessing the client's living situation for safety

B. Providing detailed therapy notes and records

C. Encouraging the client to minimize stressful interactions

D. Advocating for voluntary hospitalization only

Assessing the client's living situation for safety is a critical component of discharge planning for a client with a history of suicidal ideation. Ensuring that the client will return to an environment that minimizes the risk of self-harm is essential. This assessment allows healthcare providers to identify any potential hazards, such as access to means of self-harm, and to plan for modifications or additional support to protect the client's safety. In this context, understanding the living situation also involves evaluating the presence of supportive individuals and the overall emotional climate of the home. A safe and supportive environment can significantly reduce the risk of suicidal thoughts or behaviors resurfacing after discharge. The other choices, while they may have relevance in broader treatment contexts, do not address the immediate safety needs in discharge planning as effectively. For instance, providing therapy notes might not contribute directly to the client's safety after discharge. Encouraging the client to minimize stressful interactions could be helpful, but it doesn't focus on the structural safety elements that are vital in preventing suicidal ideation. Lastly, advocating for hospitalization may be appropriate in specific circumstances, but it is not a proactive step in discharge planning for safety at home.

8. Which food should a client taking phenelzine (Nardil) avoid?

A. Roasted chicken.

B. Salami.

C. Fresh fish.

D. Hamburger.

Phenelzine (Nardil) is a monoamine oxidase inhibitor (MAOI) used primarily in the treatment of depression. One of the critical considerations for clients taking MAOIs is their dietary restrictions, particularly concerning foods that contain tyramine. Tyramine is an amino acid that can cause hypertensive crises when consumed in large amounts while on MAOIs, as the medication inhibits the enzyme responsible for breaking down tyramine. Salami is a type of cured meat that typically contains high levels of tyramine due to the fermentation process it undergoes. Consuming salami while on phenelzine can lead to a dangerous increase in blood pressure, resulting in symptoms such as severe headache, sweating, and palpitations. Therefore, clients taking phenelzine should strictly avoid salami and other similar aged or fermented foods. In contrast, foods like roasted chicken, fresh fish, and hamburger generally do not contain significant amounts of tyramine and are safe options. While it is essential for anyone on MAOIs to follow specific dietary guidelines, avoiding salami is particularly critical due to its high tyramine content and the risk associated with consuming it while on phenelzine.

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9. When developing a care plan for a client with suicidal ideation, what should the nurse prioritize?

A. Self-esteem

B. Sleep

C. Hygiene

D. Safety

When developing a care plan for a client with suicidal ideation, prioritizing safety is crucial. The foremost concern in such cases is to ensure that the individual is protected from self-harm or suicide attempts. This involves assessing the risk factors for suicide, creating an environment that minimizes access to means of self-harm, and implementing strategies to keep the client safe, such as close observation or interventions that promote open communication about their feelings and thoughts. By focusing on safety, the nurse can help establish a foundation for further treatment. Once the immediate safety concerns are addressed, other aspects such as self-esteem, sleep, and hygiene can be incorporated into the care plan. These elements can significantly impact a person's overall well-being and mental health, but they should be secondary to ensuring that the individual is safe from self-harm in the acute phase of treatment. This hierarchical prioritization is essential in effectively managing clients with suicidal ideation.

10. What should a nurse do first when a client on phenelzine reports a throbbing headache?

A. Give the client an analgesic prescribed PRN.

B. Call the primary health care provider to report the symptom.

C. Administer the client's next dose of phenelzine.

D. Obtain the client's vital signs.

In the context of a client taking phenelzine and reporting a throbbing headache, the first action of obtaining the client's vital signs is crucial. Phenelzine is a monoamine oxidase inhibitor (MAOI) used primarily for treating depression, and it can have significant interactions with certain foods and medications. A throbbing headache could indicate a hypertensive crisis, especially if there has been a dietary indiscretion involving tyramine-rich foods, which can precipitate this serious condition. By assessing the client's vital signs initially, particularly blood pressure, the nurse can determine whether there are any alarming changes that could require immediate intervention, such as a hypertensive emergency. It's essential to gather this information before considering any other interventions, such as administering medications or contacting the healthcare provider, as the vital signs can guide the appropriate next steps in management. This assessment ensures that the nursing actions taken are based on objective clinical data, promoting patient safety and effective care.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://lippincottmooddisorders.examzify.com

We wish you the very best on your exam journey. You've got this!

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