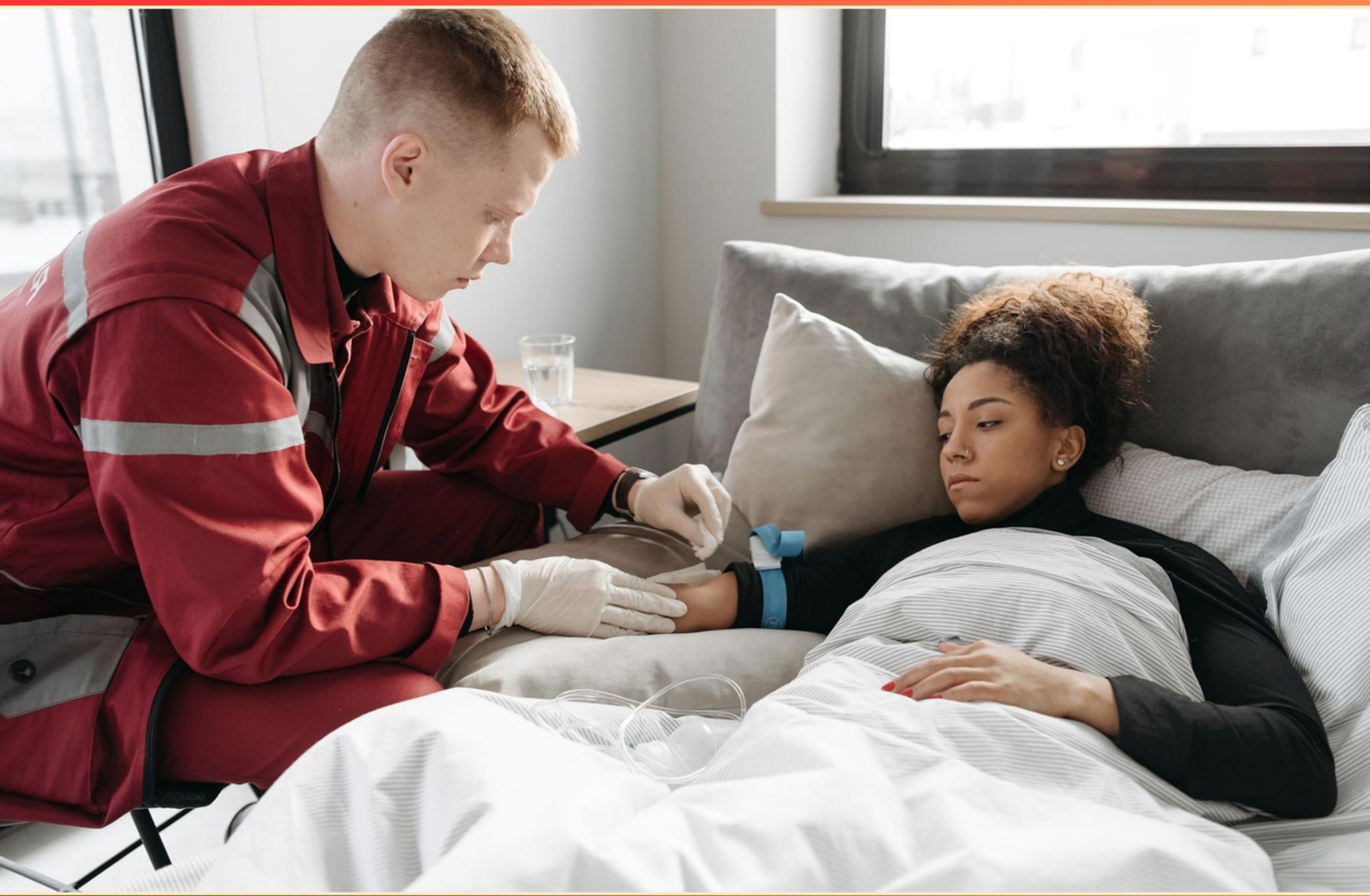
MENTAL HEALTH NURSING PSYCHOSIS PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Table of Contents

Copyright 1

Table of Contents 2

Introduction 3

How to Use This Guide 4

Questions 5

Answers 8

Explanations 10

Next Steps 16

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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 a potential risk when treating a client with schizophrenia with high doses of antipsychotics?

A. Improved cognitive function

B. Enhanced social skills

C. Neuroleptic Malignant Syndrome

D. Decreased anxiety levels

2. What condition may co-occur with psychotic disorders?

A. Substance use disorder

B. Obsessive-compulsive disorder

C. Avoidant personality disorder

D. Allergic reactions

3. Which medication would be beneficial for a child with inattention, hyperactivity, and impulsivity?

A. Atomoxetine

B. Methylphenidate

C. Clonidine

D. Lisdexamfetamine

4. What should the nurse do for a client on risperidone experiencing tremors, shortness of breath, fever, and sweating?

A. Reassure the client and monitor symptoms

B. Take the client's vital signs and arrange for immediate transfer to a hospital

C. Adjust the medication dosage

D. Document the symptoms and schedule a follow-up

5. Which drug can be administered transdermally to treat a client with major depression?

A. Fluoxetine

B. Selegiline

C. Citalopram

D. Venlafaxine

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6. A disturbed client says, "The voices are saying that I killed my husband." How should the nurse respond?

A. That's not true; you are safe now.

B. It sounds like you're feeling very distressed.

C. Let's talk about your feelings.

D. You should ignore those thoughts.

7. When a young client experiences a hallucination by mistaking a linen sheet for a ghost, what is this condition called?

A. Delusion

B. Illusion

C. Hallucination

D. Psychosis

8. In a startling situation, when a client claims, "I'm a table," what is the most appropriate response for the nurse?

A. Laugh and ignore the comment

B. Encourage the client to stand up

C. Hold out a hand and say, "You're not a table; you're a person."

D. Ask the client to explain what they mean

9. When caring for a client with pathologic suspicion, what should a nurse aim to achieve?

A. Increase the client's medication dosage

B. Help the client feel accepted by the staff

C. Encourage isolation for safety

D. Confront the client's fears directly

10. After ruling out command hallucinations, what should the nurse's next planned intervention be for a client experiencing a relapse of psychotic symptoms?

A. Increasing medication dosage.

B. Assisting the client in recognizing hallucinations when they occur.

C. Scheduling family therapy sessions.

D. Providing immediate distraction techniques.

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Answers

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

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Explanations

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1. What is a potential risk when treating a client with schizophrenia with high doses of antipsychotics?

A. Improved cognitive function

B. Enhanced social skills

C. Neuroleptic Malignant Syndrome

D. Decreased anxiety levels

The potential risk associated with treating a client with schizophrenia using high doses of antipsychotics is the development of Neuroleptic Malignant Syndrome (NMS). NMS is a serious reaction that can occur in response to antipsychotic medications, characterized by symptoms such as severe muscle rigidity, fever, autonomic instability, and altered mental status. This condition requires immediate medical attention as it can be life-threatening. High doses of antipsychotics can increase the likelihood of experiencing severe side effects, including NMS, due to alterations in neurotransmitter levels and imbalances in the body's neuroregulatory mechanisms. Monitoring and careful management of medication doses are essential to minimize this risk and ensure patient safety. The other options highlight outcomes that are generally desired or represent benefits of antipsychotic treatment rather than risks. Improved cognitive function, enhanced social skills, and decreased anxiety levels are not typical consequences of high doses and can sometimes be hindered by the side effects of these medications, particularly at elevated dosages. Thus, understanding the serious risks like NMS is crucial for effective treatment planning and patient care in individuals with schizophrenia.

2. What condition may co-occur with psychotic disorders?

A. Substance use disorder

B. Obsessive-compulsive disorder

C. Avoidant personality disorder

D. Allergic reactions

The co-occurrence of substance use disorder with psychotic disorders is well-established in mental health research. Many individuals with psychotic disorders may turn to substances as a form of self-medication or may develop a substance use disorder due to drug-induced psychosis. Substances such as alcohol, stimulants, and hallucinogens can exacerbate or mimic psychotic symptoms, making the disorders challenging to differentiate and treat. Understanding this relationship is crucial for healthcare providers as it underscores the importance of assessing and addressing substance use when treating patients with psychotic disorders. On the other hand, while obsessive-compulsive disorder may co-occur with many mental health conditions, it does not have the same strong, direct association with psychotic disorders as substance use disorders. Similarly, avoidant personality disorder and allergic reactions do not typically show a notable connection with the onset or exacerbation of psychosis, making them less relevant in the context of co-occurring conditions.

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3. Which medication would be beneficial for a child with inattention, hyperactivity, and impulsivity?

A. Atomoxetine

B. Methylphenidate

C. Clonidine

D. Lisdexamfetamine

Atomoxetine is a non-stimulant medication that is used to treat attention-deficit hyperactivity disorder (ADHD) in children and adults. It works by selectively inhibiting the reuptake of norepinephrine, which is thought to help improve focus and decrease impulsivity and hyperactivity. This medication can be particularly beneficial for individuals who may have contraindications to stimulant medications or who experience significant side effects from them. While other medications listed, such as methylphenidate and lisdexamfetamine, are also effective in managing symptoms of ADHD, they are stimulant medications that may not be suitable for every child. For instance, some children may have a history of anxiety or heart problems, making non-stimulant options like atomoxetine preferable. Clonidine, although sometimes used for ADHD, is typically employed for its calming effects and may not specifically target inattention and hyperactivity to the same extent that atomoxetine can. Thus, for children exhibiting symptoms of inattention, hyperactivity, and impulsivity, atomoxetine serves as a beneficial treatment option, particularly in the context of managing these symptoms without the use of stimulants.

4. What should the nurse do for a client on risperidone experiencing tremors, shortness of breath, fever, and sweating?

A. Reassure the client and monitor symptoms

B. Take the client's vital signs and arrange for immediate transfer to a hospital

C. Adjust the medication dosage

D. Document the symptoms and schedule a follow-up

In cases where a client on risperidone presents with tremors, shortness of breath, fever, and sweating, these symptoms could indicate a serious condition potentially linked to neuroleptic malignant syndrome (NMS) or other serious medication reactions. Such symptoms reflect significant distress and potential danger to the client's health, warranting immediate medical intervention. Taking the client's vital signs is a critical first step to assess the severity of their condition. Shortness of breath and fever may suggest an urgent need for intervention, and these vital signs can provide crucial information for further assessment and treatment. Arranging for the client's immediate transfer to a hospital is essential to ensure that they receive prompt evaluation and management from a medical team, which is necessary in urgent or life-threatening situations. Addressing acute and serious side effects effectively is paramount in nursing care. Other responses, such as reassuring the client while merely monitoring symptoms or adjusting the medication dosage without a comprehensive medical evaluation, do not adequately address the potential severity of the client's condition. Documenting symptoms and scheduling a follow-up might also lead to unacceptable delays in receiving the necessary medical care when urgent intervention is required. Therefore, arranging for immediate transfer to a hospital is the most appropriate and effective response in this scenario.

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5. Which drug can be administered transdermally to treat a client with major depression?

A. Fluoxetine

B. Selegiline

C. Citalopram

D. Venlafaxine

Selegiline is a medication primarily used as an antidepressant, particularly in the treatment of major depression. What sets selegiline apart from the other options is its availability in a transdermal patch formulation. This unique delivery method allows the medication to be absorbed through the skin, providing a steady release of the drug into the bloodstream, which can enhance adherence and minimize gastrointestinal side effects that oral medications might cause. The transdermal route is particularly beneficial for patients who may have difficulty swallowing pills or who experience significant gastrointestinal side effects from oral medications. The patch system also allows for a more stable plasma concentration of the drug, which may contribute to improved efficacy and reduced side effects. In contrast, the other medications listed — fluoxetine, citalopram, and venlafaxine — are typically administered orally and do not have a transdermal formulation available for use in treating major depression. This makes selegiline the only option among the correct answers for the transdermal administration route in the context of major depression treatment.

6. A disturbed client says, "The voices are saying that I killed my husband." How should the nurse respond?

A. That's not true; you are safe now.

B. It sounds like you're feeling very distressed.

C. Let's talk about your feelings.

D. You should ignore those thoughts.

Responding with "It sounds like you're feeling very distressed" acknowledges the client's experience with the voices they are hearing, which is critical in building trust and rapport. This kind of response reflects empathy and validates the client's emotional state without directly challenging or dismissing their perceptions. Understanding that the client is experiencing a disturbance in reality is key to providing appropriate support. By recognizing their distress, the nurse creates a safe environment where the client feels heard and understood. This can help de-escalate anxiety and promote engagement in further communication. Responses suggesting denial of the client's feelings or experiences could lead to increased distress or a feeling of isolation. Merely stating they are safe does not address the emotional turmoil expressed by the client, and suggesting to ignore their thoughts may inadvertently minimize what they are going through, which could hinder therapeutic communication. Engaging with the client about their feelings can foster a space for them to explore their thoughts in a therapeutic manner, but it may not be as immediate in addressing their distress as the correct response.

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7. When a young client experiences a hallucination by mistaking a linen sheet for a ghost, what is this condition called?

A. Delusion

B. Illusion

C. Hallucination

D. Psychosis

The situation described, where a young client mistakes a linen sheet for a ghost, is classified as an illusion. An illusion occurs when a real external stimulus is misperceived; in this case, the linen sheet is the actual object, but the client misinterprets it as something other than what it is—specifically, a ghost. Illusions are often based on sensory misinterpretations where the physical reality is present, but the perception is incorrect. Hallucinations, in contrast, are perceptions that occur without any external stimulus; they involve seeing, hearing, or feeling something that isn't actually there. Delusions refer to strongly held false beliefs that are resistant to reasoning or confrontation with actual fact. Psychosis is a broader term for a mental state that involves a disconnection from reality, which can include both hallucinations and delusions but does not specifically define the nature of the misperception involved. Therefore, the correct identification of the scenario as an illusion highlights the importance of understanding how perceptions can distort reality in psychological contexts.

8. In a startling situation, when a client claims, "I'm a table," what is the most appropriate response for the nurse?

A. Laugh and ignore the comment

B. Encourage the client to stand up

C. Hold out a hand and say, "You're not a table; you're a person."

D. Ask the client to explain what they mean

In a situation where a client expresses a delusion or a distorted belief, such as claiming, "I'm a table," an appropriate response is to provide gentle, empathetic guidance while acknowledging the client's reality. By holding out a hand and stating, "You're not a table; you're a person," the nurse effectively grounds the client in reality while also demonstrating care and validation. This response helps the client feel understood without dismissing their experience outright, which can be crucial in fostering trust and rapport. This approach does not belittle the client's feelings or beliefs but instead redirects them toward a more accurate self-concept. It is vital to remain calm and supportive, as a confrontational or dismissive approach can escalate distress or confusion for the client. In therapeutic settings, it is important to guide without insisting the client abandon their belief immediately, thus utilizing an approach that promotes understanding and connection. In contrast, laughing or ignoring the comment undermines the client's feelings and can create a perception of ridicule or disregard, which is counterproductive to building a therapeutic relationship. Encouraging the client to stand up also misses the opportunity to engage with the underlying belief in a meaningful way, and might leave the client feeling unvalidated. Asking the client to explain what they mean could be

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9. When caring for a client with pathologic suspicion, what should a nurse aim to achieve?

A. Increase the client's medication dosage

B. Help the client feel accepted by the staff

C. Encourage isolation for safety

D. Confront the client's fears directly

In the context of providing care to a client experiencing pathologic suspicion, helping the client feel accepted by the staff is a pivotal goal. Clients with such symptoms often feel misunderstood or alienated, which can exacerbate their feelings of suspicion and anxiety. Establishing a connection and fostering a sense of acceptance is crucial for building trust, which can serve as a foundation for effective therapeutic interaction. By creating an environment of acceptance, the nurse promotes a sense of safety, which may help the client open up about their thoughts and feelings. This rapport can significantly reduce the client's anxiety and encourage greater engagement in treatment. Supportive relationships can also mitigate the intensity of suspicious thoughts, as the client may begin to perceive the staff as allies rather than adversaries. Pathologic suspicion can lead to reluctance in engaging with healthcare providers, making it essential for the nursing team to adopt an empathetic stance. This approach is foundational in psychiatric nursing, where the quality of the nurse-client relationship directly impacts the overall treatment outcomes.

10. After ruling out command hallucinations, what should the nurse's next planned intervention be for a client experiencing a relapse of psychotic symptoms?

A. Increasing medication dosage.

B. Assisting the client in recognizing hallucinations when they occur.

C. Scheduling family therapy sessions.

D. Providing immediate distraction techniques.

Assisting the client in recognizing hallucinations when they occur is a crucial intervention following the ruling out of command hallucinations. This approach empowers the client to identify and understand their experiences, which can contribute to reducing anxiety and increasing awareness of what is happening. By helping the client distinguish between reality and their hallucinations, the nurse encourages self-monitoring, which is vital in managing psychotic symptoms. This recognition can also serve as a foundation for developing coping strategies and engaging in therapeutic conversations about their experiences. Increasing medication dosage, while it may be necessary in some cases, should not be the first line of intervention without a thorough assessment of the client's overall mental state and prior medication efficacy. Scheduling family therapy sessions can be valuable for ongoing support, but it does not directly address the immediate needs of the client experiencing acute hallucinations. Providing immediate distraction techniques can offer temporary relief, but it does not equip the client with the skills to manage their symptoms in the long term. Therefore, focusing on recognition of hallucinations is an essential step in the therapeutic process for clients experiencing a relapse of psychotic symptoms.

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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://mentalhealthnursingpsychosis.examzify.com

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

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