Lippincott Mood Disorders Practice Exam (Sample)

Study Guide

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Questions

1. What is a priority nursing intervention for a client with bipolar disorder experiencing a manic episode?

A. Order and administer all medications in liquid form

B. Base permission for family visits on the client's attendance at therapy groups

C. Encourage the client to keep a journal about feelings and emotions

D. Closely monitor the client's eating and sleeping habits

2. Which medication might contribute to the development of a manic state in a bipolar disorder client?

A. Amitriptyline

B. Prednisone

C. Buspirone

D. Gabapentin

3. 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.

4. Which condition is a primary reason for hospital admission in severe depression cases?

A. Inability to perform daily activities.

B. Severe behavioral disturbance.

C. Risk of self-harm or suicide.

D. Inability to maintain personal hygiene.

5. What should the nurse do if a client expresses suicidal thoughts on the unit?

A. Encourage the client to talk about feelings

B. Redirect the client to another activity

C. Leave the client alone for a while

D. Document the client's feelings

6. A client recently discharged from a psychiatric unit states she has turned on the gas to kill herself. Which action should the nurse take next?

A. Refer the caller to a 24-hour suicide hotline

B. Tell the caller that another nurse will telephone the police

C. Ask the caller whether she telephoned her primary health care provider

D. Instruct the caller to telephone her family for help

7. Which statement by a family member indicates a need for additional teaching about depression?

A. My husband will slowly feel better as his medicine takes effect over the next 2 to 4 weeks.

B. My wife will need to take her antidepressant medicine and go to group to stay well.

C. My son will only need to attend outpatient appointments when he starts to feel depressed again.

D. My mother might need help with grocery shopping, cooking, and cleaning for a while.

8. What is the most appropriate nurse response to a client exhibiting a flat affect and psychomotor retardation who does not respond to interaction?

A. "I'll sit here with you for 15 minutes."

B. "I'll come back a little bit later to talk."

C. "I'll find someone else for you to talk with."

D. "I'll get you something to read."

9. A client has a valproic acid level of 15 mg/mL. Which symptoms might this suggest?

A. "Anhedonia."

B. "Irritability."

C. "Hypersomnia."

D. "Grandiosity."

10. If a suicidal client begins to bang her head against the wall after administration of lorazepam, what should the nurse do next?

A. Tell the client to stop

B. Place the client in leather restraints

C. Call for additional medication

D. Instruct a staff member to sit with the client

Answers

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

Explanations

1. What is a priority nursing intervention for a client with bipolar disorder experiencing a manic episode?

A. Order and administer all medications in liquid form

B. Base permission for family visits on the client's attendance at therapy groups

C. Encourage the client to keep a journal about feelings and emotions

D. Closely monitor the client's eating and sleeping habits

In managing a client with bipolar disorder who is experiencing a manic episode, closely monitoring the client's eating and sleeping habits is a pivotal nursing intervention. During mania, individuals often have altered sleep patterns, ranging from insomnia to excessive energy that prevents them from realizing the need for rest. This state can lead to significant physical and cognitive impairments. Additionally, patients may neglect their nutritional needs due to heightened activity, impulsivity, or a lack of focus. By maintaining a vigilant watch over these habits, the nurse can help ensure that the client is receiving adequate nutrition and rest, which are essential for stabilizing mood and improving overall well-being. Monitoring can also provide early indications of potential complications, such as dehydration or malnutrition, and allows for timely interventions. While other options may have their merits, they do not address the immediate physiological and psychological needs critical during a manic episode. Journal-keeping and permission for family visits, while potentially beneficial, do not prioritize the most pressing challenges that the individual may face during this heightened state.

2. Which medication might contribute to the development of a manic state in a bipolar disorder client?

A. Amitriptyline

B. Prednisone

C. Buspirone

D. Gabapentin

Prednisone, a corticosteroid, can indeed contribute to the development of a manic state in clients with bipolar disorder. This medication can influence mood and lead to mood disturbances, including mania due to its effects on neurotransmitter systems and hormonal balance. Corticosteroids like prednisone can cause heightened energy levels, irritability, and agitation, which may trigger a manic episode in individuals predisposed to mood disorders. In the context of bipolar disorder, introducing a medication that can induce mania necessitates careful monitoring by healthcare providers. While certain antidepressants and medications may carry similar risks, prednisone's classification as a corticosteroid distinguishes it in terms of its known potential to destabilize mood in those with bipolar disorder. The other medications listed, such as amitriptyline, buspirone, and gabapentin, while they may have various side effects, are less commonly associated with triggering mania. Amitriptyline, for example, is a tricyclic antidepressant and could theoretically contribute to mood elevation, but it is generally not as strongly linked to the onset of manic episodes as corticosteroids are.

3. 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.

4. Which condition is a primary reason for hospital admission in severe depression cases?

A. Inability to perform daily activities.

B. Severe behavioral disturbance.

C. Risk of self-harm or suicide.

D. Inability to maintain personal hygiene.

In the context of severe depression, the risk of self-harm or suicide is a critical factor that often necessitates hospital admission. This risk indicates that an individual may have thoughts or plans to harm themselves, which poses an immediate danger to their safety. Hospitalization serves as an essential intervention to ensure the individual's protection, allowing for a comprehensive evaluation and the initiation of appropriate treatment in a controlled and supportive environment. While the inability to perform daily activities, severe behavioral disturbances, and challenges in maintaining personal hygiene are significant concerns associated with major depressive episodes, they do not inherently pose an immediate threat to life. Addressing suicidal ideation and self-harm is prioritized in clinical settings because the potential for self-injury directly influences the urgency and intensity of care required. Thus, the emphasis on suicide risk reflects the paramount importance of ensuring the individual's safety in the treatment of severe depression.

5. What should the nurse do if a client expresses suicidal thoughts on the unit?

A. Encourage the client to talk about feelings

B. Redirect the client to another activity

C. Leave the client alone for a while

D. Document the client's feelings

When a client expresses suicidal thoughts, encouraging them to talk about their feelings is a crucial intervention. This approach allows the client to openly share their thoughts and emotions, which can provide valuable insights into their mental state and the reasons behind their feelings. It fosters a trusting nurse-client relationship, demonstrating that the nurse is actively listening and is concerned about the client's well-being. Engaging the client in conversation can also help in assessing the severity of their thoughts and exploring their coping mechanisms, ultimately guiding the nurse in determining the appropriate level of care and interventions needed. Moreover, promoting open dialogue can help reduce feelings of isolation and hopelessness that individuals may experience when grappling with such thoughts. This intervention aligns with therapeutic communication strategies that emphasize validation and support, which are essential in managing clients with suicidal ideation. Understanding the client's feelings deeply can also lead to timely referrals to mental health professionals, if necessary, ensuring that they receive the appropriate treatment and support.

6. A client recently discharged from a psychiatric unit states she has turned on the gas to kill herself. Which action should the nurse take next?

A. Refer the caller to a 24-hour suicide hotline

B. Tell the caller that another nurse will telephone the police

C. Ask the caller whether she telephoned her primary health care provider

D. Instruct the caller to telephone her family for help

The appropriate response in this clinical situation prioritizes the immediate safety of the individual who has expressed suicidal intent. When a client communicates that they have turned on the gas with the intention to harm themselves, this indicates a severe and urgent risk. The nurse's responsibility is to ensure the person's safety as quickly as possible. Informing another nurse to contact the police is critical because the police or emergency services need to intervene promptly to prevent potential harm. This action ensures that trained professionals can respond immediately, assess the situation, and provide the necessary assistance to address the life-threatening risk. Engaging emergency services is a fundamental step in managing a suicide crisis effectively. Other responses, such as referring to a hotline or suggesting the individual contact family or a primary healthcare provider, may not provide the immediate help required in this scenario. While these options can be part of a supportive plan or follow-up care, they do not address the immediate and acute danger posed by the client's current actions. Therefore, contacting authorities directly is the most appropriate and effective course of action in this situation.

7. Which statement by a family member indicates a need for additional teaching about depression?

A. My husband will slowly feel better as his medicine takes effect over the next 2 to 4 weeks.

B. My wife will need to take her antidepressant medicine and go to group to stay well.

C. My son will only need to attend outpatient appointments when he starts to feel depressed again.

D. My mother might need help with grocery shopping, cooking, and cleaning for a while.

The statement indicating a need for additional teaching about depression is the one that suggests attending outpatient appointments only when feeling depressed again. This reflects a misunderstanding of the nature of depression and its treatment. Depression is a chronic condition that often requires ongoing management, which can include regular appointments with mental health professionals, taking prescribed medications consistently, and participating in therapeutic activities, regardless of the immediate emotional state. Just waiting until symptoms reappear to seek help can lead to a worsening of the condition and potentially more serious consequences. In contrast, the other statements demonstrate a better understanding of how depression management typically works. Recognizing that medication takes time to show effects and that ongoing engagement in treatment, such as attending group therapy and seeking help for daily tasks, is important reflects a more comprehensive grasp of what supporting a loved one with depression involves. Regular follow-up and proactive management are key to maintaining mental wellness in those affected by depression.

8. What is the most appropriate nurse response to a client exhibiting a flat affect and psychomotor retardation who does not respond to interaction?

A. "I'll sit here with you for 15 minutes."

B. "I'll come back a little bit later to talk."

C. "I'll find someone else for you to talk with."

D. "I'll get you something to read."

The most appropriate response, which involves sitting with the client for 15 minutes, is based on the understanding that clients exhibiting a flat affect and psychomotor retardation may be experiencing severe depressive symptoms or other mood disorders. This response demonstrates empathy and provides the individual with a sense of presence and support without forcing interaction. Sitting quietly allows the client to feel less isolated and acknowledges their distress without putting pressure on them to engage. This approach is particularly important since individuals in this state might find it difficult to initiate conversation or respond to stimuli. The presence of the nurse can convey understanding and acceptance, which are vital components in establishing rapport. Other responses, while potentially well-meaning, may not effectively address the immediate emotional state of the client. For example, saying that the nurse will come back later suggests a lack of immediate support, which might reinforce the client's feelings of abandonment. Offering to find someone else to talk with could make the client feel dismissed. Similarly, offering a reading material may not engage the client who may not have the capacity to focus or derive comfort from reading at that moment. Therefore, the approach of simply sitting with the client provides a foundation of care and stability that is crucial in such situations.

9. A client has a valproic acid level of 15 mg/mL. Which symptoms might this suggest?

A. "Anhedonia."

B. "Irritability."

C. "Hypersomnia."

D. "Grandiosity."

A valproic acid level of 15 mg/mL suggests that the concentration is below the therapeutic range typically considered effective for mood stabilization, particularly in the treatment of bipolar disorder. The usual therapeutic level for valproate in the context of mood disorders generally falls between 50 to 100 µg/mL (or 50 to 100 mg/mL, depending on the specific measurement context). Therefore, a level of 15 mg/mL indicates that the medication may not be adequately managing symptoms. Irritability is a common symptom experienced by individuals with mood disorders, and it can become pronounced when medications like valproic acid are not at therapeutic levels. As the mood stabilizing effects are compromised, the individual may exhibit increased mood swings or irritability, indicating that the current valproate dose might require adjustment or that additional interventions may be necessary to achieve mood stabilization. The other options, while they can be symptoms associated with mood disorders, are not as directly related to a low level of valproic acid. Anhedonia pertains more to a lack of pleasure, hypersomnia is related to excessive sleeping, and grandiosity can be associated with manic episodes; none of these are as directly connected to the implications of a subtherapeut

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B. Place the client in leather restraints

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In a situation where a suicidal client exhibits self-harm behaviors, such as banging her head against the wall, the priority is to ensure the safety and well-being of the client. Placing the client in leather restraints is a response aimed directly at preventing further harm that the client may inflict on herself. This intervention is necessary when a client's behavior poses an immediate risk to her physical safety and cannot be managed by less restrictive means. Using restraints should always be considered a last resort after other interventions have been attempted. However, in this specific scenario where the client's actions indicate a high risk of serious injury, the immediate action to ensure safety is crucial. In conjunction with this measure, it is also important for healthcare professionals to engage in ongoing evaluation and monitoring of the client's condition and to re-evaluate the need for restraints frequently. Other options may not adequately address the client's immediate needs. Simply telling the client to stop doesn't provide the necessary intervention for self-harm. Calling for additional medication may delay urgent action needed to contain the situation. Instructing another staff member to sit with the client, while supportive, does not directly prevent the client from harming herself and is therefore not the most effective immediate response.