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Nursing Q-Bank Series

For BSc Nursing Students

Mental Health Nursing-I & II

As per the Revised INC Syllabus



HIGHLIGHTS

- Various University Examination Question Papers
- Learning Pearls

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UNIT 7: NURSING MANAGEMENT OF PATIENTS WITH MOOD DISORDERS

Note: *In this Unit, we have covered following questions. These questions are taken after detailed analysis from the questions bank of various universities.*

LONG QUESTIONS

Sl. No.	Question	Marks
Q1.	Define bipolar affective disorder (BPAD). Explain its classification. Discuss in detail about etiology, signs and symptoms and nursing management of patient with mania.	3 + 7
Q2.	Define depression. Explain etiology and clinical features of depression. Write the nursing management of patient with severe depression.	2 + 4 + 4

SHORT QUESTIONS

Sl. No.	Question	Marks
Q1.	Bipolar I and II	5
Q2.	Diagnostic criteria of depression	5
Q3.	Psychopathology of mood disorders	5
Q4.	Psychopharmacological treatment of depression	
Q5.	Management of patient with depression	5
Q6.	Follow up, home care and rehabilitation of mood disorders	5

VERY SHORT QUESTIONS

Sl. No.	Question	Marks
Q1.	Define depression.	2
Q2.	Define anxiety.	2
Q3.	List the types of mood disorders.	2
Q4.	Mention any four clinical features of mania.	2
Q5.	Puerperal mood disorder.	2
Q6.	Discuss in detail about mood in typical mania patient.	2
Q7.	Differentiate between endogenous and exogenous depression.	2
Q8.	Lithium carbonate.	2

MULTIPLE CHOICE QUESTIONS

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UNIT 7

NURSING MANAGEMENT OF PATIENTS WITH MOOD DISORDERS

LONG QUESTIONS

Q1 Define bipolar affective disorder (BPAD). Explain its classification. Discuss in detail about etiology, signs and symptoms and nursing management of patient with mania.

Ans. Bipolar Affective Disorder (BPAD), also known as bipolar disorder, is a mental health condition characterized by extreme mood swings that include ***episodes of mania or hypomania*** (abnormally elevated mood) and ***depression***. These mood swings can significantly impact a person's ability to function in daily life, affecting relationships, work, and overall well-being.

Classification of BPAD

Bipolar I Disorder (Bipolar Type I)

- **Manic episodes:** This type of bipolar disorder is defined by ***at least one manic episode*** lasting at least seven days or requiring hospitalization. The manic episode can be severe and impair social or occupational functioning.
- **Depressive episodes:** Often, individuals with bipolar I also experience ***depressive episodes***, but it is not required for the diagnosis.
- **Hypomanic episodes:** These may also occur, but the diagnosis is based on the manic episode.

Bipolar II Disorder (Bipolar Type II)

- **Hypomanic episodes:** Individuals with bipolar II experience hypomanic episodes, which are less severe than manic episodes. These episodes last for at least 4 days but do not cause significant impairment in social or occupational functioning.
- **Depressive episodes:** This type of BPAD includes recurrent major depressive episodes that last for at least two weeks.

Cyclothymic Disorder (Cyclothymia)

- **Mild symptoms:** Cyclothymic disorder involves numerous periods of hypomanic symptoms and depressive symptoms that do not meet the full criteria for hypomania or major depression.
- **Duration:** These mood swings must last for at least 2 years (1 year in children and adolescents), with periods of stability lasting no longer than 2 months.

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Other Specified Bipolar and Related Disorders

This category includes cases where a person has mood episodes that do not fit the criteria for bipolar I, II, or cyclothymic disorder but still cause significant distress or impairment.

Unspecified Bipolar and Related Disorders

This diagnosis is used when a person has symptoms that appear to fit a bipolar disorder but do not meet the full criteria for any of the other specific types. The cause of the mood disturbances is unclear or unspecified.

Etiology of Mania

- **Genetic predisposition** plays a significant role, with familial and twin studies indicating a strong hereditary component. Variations in genes affect neurotransmitter systems, particularly dopamine and serotonin.
- **Neurobiological factors** include dysregulation in brain circuits involving the prefrontal cortex, limbic system, and amygdala, leading to impaired emotional regulation and heightened reward sensitivity. Neurotransmitter imbalances, including elevated dopamine and norepinephrine levels, are central to manic symptoms.
- **Environmental factors,** such as stress, sleep deprivation, and substance abuse can precipitate mania in susceptible individuals. Psychosocial stressors, including traumatic events, also increases the risk.
- Hormonal dysregulation, particularly involving the hypothalamic-pituitary-adrenal (HPA) axis, and circadian rhythm disturbances are also key contributors.

Sign and Symptoms of Mania

Mania is characterized by a distinct period of abnormally elevated, expansive, or irritable mood, accompanied by increased energy and activity. Main signs and symptoms include:

- **Euphoria or irritability:** Unusually elevated mood or easily provoked anger.
- **Increased energy:** Restlessness and decreased need for sleep without feeling tired.
- **Rapid speech:** Pressured, fast, and difficult-to-interrupt talking.
- **Racing thoughts:** Flight of ideas or quickly jumping from topic to topic.
- **Grandiosity:** Inflated self-esteem or unrealistic beliefs in one's abilities.
- **Impulsivity:** Engaging in risky behaviors, such as reckless spending, substance use, or promiscuity.
- **Distractibility:** Difficulty focusing due to heightened sensitivity to external stimuli.
- **Goal-directed activity:** Excessive involvement in work, projects, or social plans, often without completing them.

Nursing Management of Mania

Risk of Injury Related to more Hyperactivity and Impulsive Behavior as Evidenced by Injurious Activities

Interventions

- Assess the environmental stimulus which can be cause of injury.
- Remove the hazardous objects.
- Assist the client in performing some activities.

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- Be with the client when hyperactivity increases.
- Administer psychotropics as per physician's order.

Risk of Violence Directed to Self and Others Related to Increased Excitement

Interventions
- Observe the client for every 15 minutes to ensure safety.
- Encourage the client to ventilate his/her feelings.
- Use diversional therapies to divert the client's mind.
- Talk to the client with calm attitude.
- Apply restraints if the client is harming to self or others.

Impaired Nutritional Status Less than Body Requirement Related to Inability to Eat es Evidenced by Significant Weight Loss

Interventions
- Assess the nutritional status of the client.
- Maintain intake-output chart.
- Calculate the client's body mass index (BMI).
- Stay with the client when he/she eats.
- Give high protein and high caloric diet.

Impaired Family Coping Skills Related to Flight of Ideas as Evidenced by Family Disputes

Interventions
- Assess the communication level among family members.
- Identify the feelings of the family members.
- Identify the role of the client in family.
- Provide family therapy to enhance the coping skills.

Q2 Define depression. Explain etiology and clinical features of depression. Write the nursing management of patient with severe depression.

Ans. Definition: Depression is a common and serious mental health disorder characterized by a persistent feeling of sadness, low mood, and a loss of interest or pleasure in activities once enjoyed. It often affects how a person feels, thinks, and behaves, leading to emotional and physical problems. Depression can significantly impair daily functioning, relationships, and quality of life.

To be clinically diagnosed as **major depressive disorder (MDD)**, symptoms must persist for at least two weeks and cause significant distress or impairment in social, occupational, or other important areas of functioning. It is distinct from occasional sadness or grief and requires professional evaluation and treatment.

Etiology of Depression

Depression is a complex disorder with a multifactorial etiology involving genetic, biological, psychological, and environmental factors.

- **Genetic factors:** Depression often runs in families, suggesting a hereditary component. Variations in genes regulating neurotransmitters like serotonin, dopamine, and norepinephrine may increase vulnerability. Twin and family studies indicate a moderate genetic predisposition.

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- **Neurobiological factors:** Neurotransmitter imbalances, particularly reduced serotonin and norepinephrine levels, are central to depression. Dysfunction in brain regions, such as the prefrontal cortex, hippocampus, and amygdala leads to impaired emotional regulation and stress response. Altered hypothalamic-pituitary-adrenal (HPA) axis activity contributes to heightened stress sensitivity.
- **Psychosocial factors:** Adverse childhood experiences, trauma, and chronic stress are significant psychological risk factors. Negative thought patterns, low self-esteem, and maladaptive coping mechanisms further contribute.
- **Environmental factors:** Life stressors, such as financial difficulties, relationship issues, or loss of a loved one can trigger depressive episodes. Social isolation and lack of support exacerbate symptoms.
- **Other factors:** Hormonal changes (during postpartum or menopause), medical conditions (hypothyroidism, chronic illness), and substance abuse are additional contributors to depression.

Clinical Features of Depression

Core Symptoms

- **Persistent sadness or low mood:** Feeling hopeless, empty, or tearful most of the day.
- **Loss of interest or pleasure (anhedonia):** Markedly reduced enjoyment in activities once found pleasurable.

Cognitive Symptoms

- **Negative thoughts:** Feelings of worthlessness, guilt, or excessive self-criticism.
- **Impaired concentration:** Difficulty focusing, decision-making, or memory lapses.
- **Suicidal ideation:** Recurrent thoughts of death or suicide, with or without plans.

Physical Symptoms

- **Fatigue:** Persistent lack of energy, even after rest.
- **Sleep disturbances:** Insomnia (difficulty falling or staying asleep) or hypersomnia (excessive sleeping).
- **Appetite changes:** Significant weight loss or gain due to altered appetite.
- **Psychomotor changes:** Agitation (restlessness) or retardation (slowed speech or movements).

Behavioral Symptoms

Social withdrawal, decreased productivity, and neglect of personal responsibilities.

Nursing Management of Depression

Risk for Suicide Related to Suicidal Ideation as Evidenced by Suicidal Risk Determination

Interventions

- Assess the level of suicidal risk.
- Do not allow the client to be alone.

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- Remove the sharp objects from the client's room.
- Allow the client to talk about his/her emotional burden.
- Administer antidepressants as per physician's order.

Self-care Deficit Related to Lack of Energy as Evidenced by Lack of Doing Activities

Interventions
- Assess the client's interest and capacity to perform self-care activities.
- Encourage the client to do the activities by self.
- Assign the daily activities with time schedule.
- Do not rush the client to do activities.
- Simple task can be done by the client under supervision.

Hopelessness Related to Negative Attitude Towards Self as Evidence by Mental Status Assessment

Interventions
- Assess the client's actual loss and perceived loss.
- Reinforce the client regarding supporting system that help to get rid of the problems.
- Maintain therapeutic nurse-patient relationship.
- Provide counselling/behavior modification therapy.

Impaired Social Interactions Related to Social Isolation as Evidenced by Poor Interpersonal Relationship

Interventions
- Accept the client as he/she is.
- Maintain good interpersonal relationship with the client.
- Involve the client in group activities.
- Avoid competitive tasks.
- Provide social skill training to the client.

SHORT QUESTIONS

Q1 Bipolar I and II.

Ans. A bipolar mental disorder characterized by mood swings ranging from depressive lows to high manic phase. Episodes may last for weeks to months.

Manic episodes may include symptoms, such as high energy, reduced need for sleep and loss of touch with reality. **Depressive episodes** may include symptoms, such as low energy, low motivation and loss of interest in daily activities. **Mood episodes** last days to months at a time and may also be associated with suicidal thoughts.

There are four basic types of bipolar disorder:
1. Bipolar I disorder
2. Bipolar II disorder
3. Cyclothymic disorder (cyclothymia)
4. Other specified and unspecified bipolar and related disorders

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Bipolar I and II disorders are the most common types of bipolar disorder.

For more details, refer Q. No. 1 of Long Answer Questions of this unit.

Q2 Diagnostic criteria of depression.

Ans. DSM-5 diagnostic criteria for major depressive disorder: Criteria in Regard to the Recurrent Temper Outburst

Severe recurrent temper outbursts manifested either verbally (verbal rages) and/or behaviorally (physical aggression toward other persons or property) that are not proportionate in intensity or the duration to the situation are not consistent with the

- Temper outbursts are not consistent with the developmental level.
- Mood between temper outbursts is persistently irritable most of the day or nearly every day.
- Severe recurrent temper outbursts need to be present in at least two of the three settings (i.e., at home, at school, with peers) and need to be severe in at least one of these.

1. Duration:

- On average, temper outbursts happen three or more times in a week.
- All the above criteria's need to present for one year or above.
- Individual should not be present without all of the symptoms for more than three months
- Diagnosis should not be made for first time before 6 years of age or after 18 years.

2. Miscellaneous:

- Symptoms should not reflect any other mental disorders.
- Symptoms are not due to the effects of a substance use or due to another medical condition.

DSM-5 Diagnostic Criteria for Single Episode Depression

- Five or more of the following symptoms present for significant portion of time for 2 weeks period.
- Depressed mood presents almost most of the day and every day. Lack of interest or pleasure.
- Significant weight loss (without dieting) or weight gain—5% of body weight loss or gain in a month.
- Fatigue or energy loss almost every day.
- Hypersomnia or insomnia almost every day.
- Psychomotor retardation or agitation almost every day.
- Feel or worthlessness or inappropriate guilt.
- Inability to concentrate almost every day.
- Frequent thoughts of death.
- Above symptoms cause the significant social and occupational impairment.
- Above symptoms are not due to consumption of any substances.
- There should not be any manic episode.
- Occurrence of depressive episode might not be explained as other psychotic disorders.

Specify, if it is:

- With anxious distress
- With atypical features
- With melancholic features
- With mood-congruent psychotic features

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- With mood-incongruent psychotic features
- With seasonal pattern

ICD-11 Diagnostic Criteria for Single Episode Depression

- It is characterized by the presence or history of one depressive episode when there is no history of prior depressive episodes.
- Depressive episode is characterized by the period of almost daily depressed mood or lack of interest in activities lasting at least for 2 weeks along with other symptoms, such as feelings of worthlessness or excessive or inappropriate guilt, difficulty concentrating, hopelessness, recurrent thoughts of suicide or death, psychomotor agitation or retardation, changes in appetite or sleep and decrease in the energy or fatigue.
- No prior manic, hypomanic, or mixed episodes, which indicate the presence of bipolar disorder.

Specify, if it is:

- **Mild:** Less intensity, not considerable difficulty in continuing with work, social, or domestic activities and no delusions or hallucinations.
- **Moderate:** Symptoms of depression for at least 2 weeks and presence difficulty in continuing with work, social, or domestic activities.
- **Severe:** Severe depressive symptoms cause significant distress and have social or occupational impairment. With or without psychotic features.
- **Partial remission:** Full definitional requirements for a depressive episode are no longer met but some significant mood symptoms remain.
- **Full remission:** Full definitional requirements for a depressive episode has met.
- Unspecified.

ICD-11 Diagnostic Criteria for Recurrent Episode Depression

- Recurrent depressive disorder is characterized by a history or at least two depressive episodes separated by at least several months without significant mood disturbance.
- A depressive episode is characterized by a period of almost daily depressed mood or diminished interest in activities lasting at least two weeks accompanied by other symptoms, such as difficulty in concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue.
- There have never been any prior manic, hypomanic, or mixed episodes, which would indicate the presence of a bipolar disorder.

DSM-5 Diagnostic Criteria for Persistent

Depressive Disorder (OR) Dysthymic Disorder

- Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years. (In children and adolescents, mood can be irritable and duration must be at least 1 year).
- Presence, while depressed, of two (or more) of the following:
  - Poor appetite or overeating.
  - Insomnia or hypersomnia.

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- Low energy or fatigue.
- Low self-esteem.
- Poor concentration or difficulty making decisions.
- Feelings of hopelessness.

- During the 2 years period (1 year for children or adolescents) of the disturbance, the individual has never been without the presence of depressive symptoms.
  - There has never been a manic episode or a hypomanic episode, and criteria have not met for cyclothymic disorder.
  - The disturbance is not better explained by other medical or mental disorder or not due to influence of any substances.
  - Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specifications on the basis of features: Anxious distress or mixed features or melancholic features or atypical features or mood-congruent psychotic features or mood-incongruent psychotic features or peripartum onset.

Specifications on the basis of remission: Partial or full remission.

- Specifications on the basis of onset:
  - *Early onset:* If onset is before at age 21 years.
  - *Late onset:* If onset is at age 21 years or older.
  - *Specifications on the basis of severity:* Mild or moderate or severe.

Other Specifications

- With intermittent major depressive episodes, with or without current episode
- With pure dysthymic syndrome
- With persistent major depressive episode.

ICD-11 Diagnostic Criteria for Persistent Depressive Disorder (OR) Dysthymic Disorder

- Dysthymic disorder is characterized by a persistent depressive mood (i.e., lasting 2 years or more), for most of the day, for more days than not.
- In children and adolescents depressed mood can manifest as pervasive irritability. The depressed mood is accompanied by additional symptoms, such as markedly diminished interest or pleasure in activities, reduced concentration and attention or indecisiveness, low self- worth or excessive or inappropriate guilt, hopelessness about the future, disturbed sleep or increased sleep, diminished or increased appetite, or low energy or fatigue. During the first 2 years of the disorder, there has never been a 2 weeks period during which the number and duration of symptoms were sufficient to meet the diagnostic requirements for a depressive episode.
- There is no history of manic, mixed, or hypomanic episodes.

ICD-11 Diagnostic Criteria for Recurrent Depressive Disorder

- Recurrent depressive disorder is characterized by a history or at least two depressive episodes separated by at least several months without significant mood disturbance.
- A depressive episode is characterized by a period of almost daily depressed mood or diminished interest in activities lasting at least two weeks accompanied by other symptoms,

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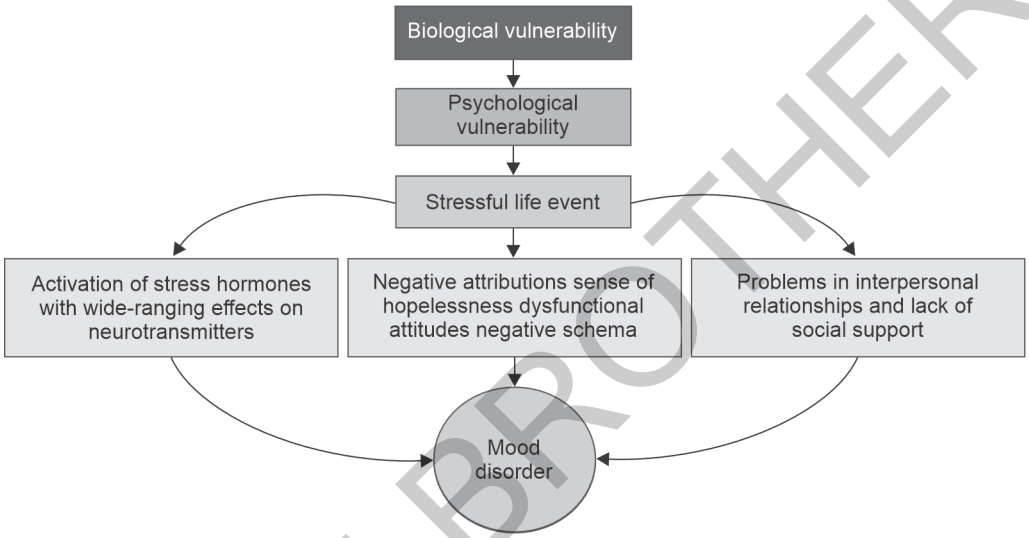
such as difficulty in concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue.
- There have never been any prior manic, hypomanic, or mixed episodes, which would indicate the presence of a bipolar disorder.

Q3 Psychopathology of mood disorders.

Ans.



Q4 Psychopharmacological treatment of depression.

Types of Antidepressants

- First generation antidepressants (or) tricyclic antidepressants (TCA)—drug of choice for severe depression.
- Second generation antidepressants (or) selective serotonin reuptake inhibitors (SSRI)—drug of choice for mild-to-moderate depression.
- Serotonin norepinephrine reuptake inhibitors (SNRI).
- Monoamine oxidase inhibitors (MAOI).
- Atypical antidepressants.

Mechanism of Action for Antidepressants (Table 7.1)

- **Monoamine hypothesis:** Deficiency of monoamines, such as serotonin, norepinephrine and dopamine leads to depression.
- Postsynaptic receptors to upregulate.
- Monoamine hypothesis of gene expression states abnormal functioning of genes that might lead to depression.

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Table 7.1: Types and mechanism of action of antidepressants.

	TCA	SSRI	SNRI	MAOI	Atypical antidepressant
Mechanism of action	• Tricyclic antidepressants (TCA) will block serotonin transporter and norepinephrine transporter primarily • Desipramine is more selective in inhibiting nore- pinephrine transporter than serotonin transporter • However, TCA also blocks alpha, histaminic and muscarinic receptors. Thus, serotonin, norepinephrine and dopamine get increased in synapse	• SSRI will block serotonin transporter (SERT) and so it will inhibit the reuptake of serotonin in presynapse • Serotonin is synthesized in serotonergic neuron by amino acid "Tryptophan • Tryptophan from vesicles starts to release into synapse and binds with the receptors of postsynapse. At the same time, there will be reuptake process too • Serotonin in the synapse is reabsorbed into presynapse by serotonin transporter (SERT) • When serotonin reuptake takes place, it partially reuptakes into vesicles and partially gets broken down into metabolites by monoamine oxidase (MAO) enzymes • Antidepressants will tend to produce maximum benefits by forming the G-protein as cluster in brain cell membrane namely lipid graft	• Serotonin norepinephrine reuptake inhibitors (SNRI) will inhibit the serotonin transporter and norepinephrine transporter and thereby reuptake process will get inhibited • Now adequate norepinephrine and serotonin will be present to bind with postsynapse	• Monoamine oxidase is present in brain, gut and liver • It has MOA-A and MOA-B: • MOA-A: Preferably metabolizes serotonin but it also metabolizes norepinephrine and dopamine • MOA-B: Preferably metabolizes dopamine. • Monoamine oxidase inhibitors will inhibit the monoamine oxidase enzyme, which then automatically decreases the availability of monoamines, such as serotonin, norepinephrine and dopamine	Increased tyramine agent, that leads to hypertensive crisis and to stroke Mechanism of action —atypical antidepressants bupropion is a weak norepinephrine and dopamine reuptake inhibitor It reduces nicotine craving. • Bupropion is a weak norepinephrine and dopamine reuptake inhibitor. It reduce nicotine craving • Mirtazapine is an alpha receptor antagonist. It also blocks histamine receptor and serotonin receptor in the postsynapse

Contd...

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Contd...

	TCA	SSRI	SNRI	MAOI	Atypical antidepressant
		• G-Protein lacks access to molecule called cyclic-AMP which is important to work with the signals of serotonin • SSRI will help to release G-protein from lipid raft and reach the membrane to function better. So, in order to carry out all the above processes, antidepressants are taken for 6 –8 weeks to get maximum benefits		• Selegiline selectively blocks MAO-B (dopamine metabolism) and so it is helpful in Parkinson's disease • MAOI has drug food interactions and is present in the gut/ intestines. The inhibited monoamines due to administration of MAOI might metabolize tyramine	• Trazadone and nefazodone will block serotonin transporter (SERT), 5-HT 2A receptor, histamine and alpha receptor • Vilazodone is serotonin (5-HT) partial agonist, i.e., it blocks serotonin transporter (SERT) and also prevents postsynaptic serotonin stimulation
Example	• Tertiary amine tricyclic antidepressants: Amitriptyline 100–200 mg, Doxepin 100–200 mg, Imipramine 100–200 mg Clomipramine 100–200 mg • Secondary amine tricyclic antidepressants: Nortriptyline 75–150 mg Protriptyline 15–40 mg Desipramine 100–200 mg Amoxapine 200–300 mg Maprotiline 100–150 mg	Fluoxetine 20–80 mg Sertraline 50–200 mg Paroxetine 20–50 mg Fluvoxamine 50–300 mg Citalopram 20–60 mg Escitalopram 10–30 mg	Venlafaxine 75–225 m Atypical antidepressants		Bupoprion (wellbutrin) 150 –450 mg Nefazodone (serzone) 200 –600 mg

Contd...

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Contd...

	TCA	SSRI	SNRI	MAOI	Atypical antidepressant
Side effects	T: Tremors C: Cardiovascular (cardiac arrhythmias, ischemic heart disease, postural hypotension) A: Anticholinergic effects S: Sedation, seizure	• Excess stimulation of serotonin in brain will cause insomnia, anxiety and irritability • Excess stimulation of serotonin in spinal serotonin receptor will cause sexual side effects (Erectile dysfunction) • Excess stimulation of serotonin in gastrointestinal system will cause nausea, vomiting and diarrhea • Abrupt withdrawal of SSRI will cause headache, nausea, vomiting, agitation and sleep disturbances	• Hypertension • Tachycardia	Hypertension, seizure, muscle rigidness, hyperthermia and mania	

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Q5 Management of patient with depression.

Ans. Following are the treatment modalities for depression

- **Psychopharmacological drugs:** Antidepressant drugs
- **Psychosocial treatment:** Although somatic treatment is the primary mode of management in major mood disorders, psychosocial treatment may be indicated in certain cases.
  - As an adjunct to somatic treatment
  - In mild cases of depression
  - Certain selected cases.

Following are the psychosocial treatment modalities of depression:

- **Cognitive behavior therapy:** Cognitive therapy or cognitive behavior
- therapy aims at correcting the depressive negative cognitions, e.g., hopelessness, worthlessness, helplessness and pre-pessimistic ideas, and replacing them by new cognitive and behavioral responses.
  It is useful in mild-to-moderate, non-bipolar depression and can be used along with somatic treatment.
- **Interpersonal therapy:** Interpersonal therapy (IPT) attempts to recognize and explore interpersonal stressors, role disputes and transitions, social isolation, or social skills deficits, which act as precipitants for depression. It is useful in the treatment of mild-to-moderate unipolar depression, with or without antidepressants.
- **Psychoanalytic psychotherapy:** The short-term psychoanalytic psychotherapies aim at changing the personality itself rather than just ameliorating the symptoms. Their usefulness is uncertain, particularly in a florid depressive or manic episode.
- **Behavior therapy:** This includes the various short-term modalities like social skills training; problem-solving techniques, assertiveness training, self-control therapy, activity scheduling and decisions making techniques. It is useful in mild cases of depression.
  Social skill training: It helps to maintain IPR with others. Eye-to-eye contact has to be maintained while speaking to others. Involving the depression patient in ward rounds can improve the social skills of the patient.
- **Group therapy:** Group psychotherapy can be useful in mild cases of depression.
- **Family and marital therapy:** Apart from educating the family about the nature of illness and usefulness of somatic treatment, family therapy has not been found very useful in mood disorders. Another use is to decrease the intrafamilial an interpersonal difficulty, and to reduce or modify stressors, which may help in a faster and more complete recovery. The main purpose is to ensure on continuity of treatment and drug compliance.

Q6 Follow-up, home care and rehabilitation of mood disorders.

- Psychological therapies rendered to elders with mood disorders have to be followed at regular intervals for higher level of efficiency.
- Negative expression emotions have to be avoided in home settings to prevent depression.
- Preventive measures of elderly abuse (physical abuse-beating, emotional abuse scolding elders, sexual abuse or granny bashing, economical abuse) will also prevent the depression.
- Rehabilitation helps to restore the elders to live with peace and it helps them to perform the activities of daily living.

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VERY SHORT QUESTIONS

Q1 Define depression.

Ans. Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest in things and activities you once enjoyed. It can also cause difficulty with thinking, memory, eating and sleeping.

Q2 Define anxiety.

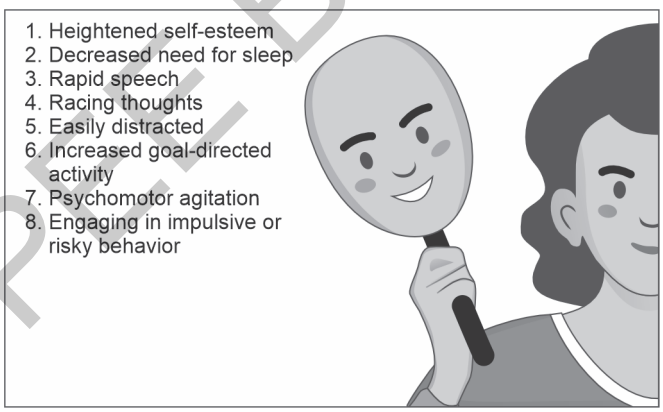
Ans. Anxiety is a common emotion, and it can cause physical symptoms, such as shaking and sweating. When anxiety becomes persistent or excessive, a person may have an anxiety disorder.

Q3 List the types of mood disorders.

Ans. These include bipolar disorder:
- Cyclothymia,
- Hypomania,
- Major depressive disorder,
- Disruptive mood dysregulation disorder,
- Persistent depressive disorder and
- Premenstrual dysphoric disorder.

Q4 Mention clinical features of mania.

Ans.



Q5 Puerperal mood disorder.

Ans. Postpartum mood disorders encompass a range of mental health conditions that occur in the postpartum period. These disorders are characterized by depressive, anxious, or psychotic symptoms that significantly impair a woman's functioning and well-being.

Q6 Discuss in detail about mood in typical mania patient.

Ans. Acute mania is the manic phase of bipolar I disorder. It is defined as an extremely unstable euphoric or irritable mood along with an excess activity or energy level, excessively rapid thought and speech, reckless behavior and feeling of invincibility.

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Q7 Differentiate between endogenous and exogenous depression.

Ans.

Aspects	Endogenous depression	Exogenous depression
Meaning	Within hereditary or biochemical	Not within hereditary
Another name	• Psychotic depression • Autogenous depression • Biological depression	• Neurotic depression • Reactive depression
Predominant factors	Biological factors	Environmental factors
Stress	Present	Present
Premorbid personality	• Cyclothymic personality • Dysthymic personality	• Anxious personality • Obsessive personality
insomnia	Early morning awakening	Struggling in getting into sleep
Psychotic feature	• Psychomotor retardation • Suicidal attempt is seen • Delusions is present	• Psychomotor agitation • Suicidal attempts are not common • Psychotic features are absent
Individual feeling	Better when alone	Better in group
Mood	Sad in morning	Sad in evening
Treatment	Antidepressant and ECT	Antidepressant and psychotherapy
Relapse	Common	Not common

Q8. Lithium carbonate.

Ans. Lithium carbonate is an inorganic compound, the lithium salt of carbonic acid with the formula Li_2CO_3. This white salt is widely used in processing metal oxides. It is on the World Health Organization's List of Essential Medicines for its efficacy in the treatment of mood disorders, such as bipolar disorder.

Lithium Carbonate Uses

Lithium carbonate is used for mania and bipolar disorder.

How Lithium Carbonate Works

Lithium carbonate works by suppressing the abnormal and excessive activity of the nerve cells in the brain.

Common Side Effects of Lithium Carbonate

Nausea, increased white blood cell count, weight gain, polyuria, headache, vomiting, dryness in mouth, hand tremors, muscle weakness, confusion, decreased memory, feeling thirsty, ECG changes, vertigo.

MULTIPLE CHOICE QUESTIONS

Q1 Value of grade 2 lithium toxicity is _____.

a. 1.5–2.5 mEq/L
b. 2.5–3.5 mEq/L
c. >3.5 mEq/L
d. 0.5 mEq/L

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Q2 **Mania commonly occurs in _____.**

a. Male
b. Female
c. Both male and female
d. None of these

Q3 **_____ coined the term mania and depression.**

a. Hippocrates
b. Emil Kraepelin
c. Aratus
d. King Saul

Q4 **Light therapy is indicated for _____.**

a. Mania
b. Seasonal affective disorder
c. Both a & b
d. None of the above

Q5 **Stage 3 mania is also called _____ .**

a. Hypomania
b. Acute mania
c. Delirious mania
d. None of these

Q6 **Drug which increase the serum lithium level are _____.**

a. Acetazolamide
b. Mannitol
c. Theophylline
d. Metrogyl

Q7 **Decreased norepinephrine and serotonin is present in _____.**

a. Mania
b. Both mania and depression
c. Depression
d. None of these

Q8 **Hypomania and depression is _____ .**

a. Bipolar I disorder
b. Bipolar II disorder
c. Both a and b
d. None of these

Q9 **ICD-11 code for current manic episode with psychotic feature is _____.**

a. 6A60.5
b. 6A61
c. 6A62.5
d. 6A62

Q10 **Stevens-Johnson Syndrome (SIS) is a side effect of _____.**

a. Sodium valproate
b. Lamotrigine
c. Carbamazepine
d. Both B and C

ANSWER KEY

1. b	2. b	3. a	4. b	5. c	6. d	7. c	8. a
9. d	10. d						

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