# MENTAL HEALTH QUESTIONS AND ANSWERS



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Questions and Answers

## Question 1

## FLORENCE NIGHTINGALE SCHOOL OF NURSING AND MIDWIFERY - NO.58

**- Outline ten (10) specific interventions that nurse implements in the management of a patient admitted with suicidal behavior until they are stable.**

### ANSWER: Examination Script

Key Terms (from PDF): Suicide: Refers to the deliberate act of self-harm that leads to loss of life or death. Suicidal Behavior: Being one of the psychiatric emergencies, it needs urgent attention since you are supposed to protect a patient from harming him or herself and destroying other properties. Aims of Management: To prevent self-harm, restore the patient's health functional state, and restore the patient's self-esteem.

1. Ensure a Safe Environment (Suicide Precautions): Remove all potentially harmful objects from the patient's room and vicinity (e.g., sharp objects like razors, scissors, glass; belts, shoelaces, cords; medications). Ensure windows are secure and doors may need to be kept open or have observation windows. Check patient's belongings for dangerous items. Reason: To reduce the immediate opportunity for self-harm.

2. Implement Close Observation: Level of observation depends on assessed risk. Constant Observation (One-to-One): For high-risk patients, a staff member stays with the patient at all times, maintaining arm's length and visual contact, even during toileting. Frequent Checks: E.g., every 15 minutes, with irregular timing so patient cannot predict. Document observation status and patient behavior. (Ensure caution card is fully signed by nurses during handover - PDF point). Reason: To monitor behavior, prevent suicide attempts, and provide immediate intervention if needed.

3. Establish a Therapeutic Nurse-Patient Relationship : Build trust and rapport. Be empathetic, non-judgmental, and respectful. Spend time with the patient, listen actively to their feelings and concerns. Reason: To encourage the patient to express suicidal thoughts and feelings, and to foster a sense of connection and hope.

4. Directly Assess Suicidal Ideation, Intent, and Plan: Ask direct questions about suicidal thoughts (e.g., "Are you having thoughts of harming yourself?"). Assess the frequency, intensity, intent, and specificity of any plan. Inquire about previous attempts and family history of suicide. (Assess for risk factors - PDF point). Reason: To understand the level of risk and guide interventions. Directly asking does NOT plant the idea.

5. Develop a Safety Plan (No-Harm Contract - use with caution and as part of broader plan): Collaborate with the patient (if able) to develop a plan for managing suicidal urges. This might include identifying coping strategies, support persons to contact, and steps to take if thoughts intensify. (No-harm contracts alone are not sufficient but can be part of a therapeutic alliance). Reason: To empower the patient and provide tools for managing crises.

6. Administer Prescribed Medications and Monitor Effects/Side Effects: Administer antidepressants, antipsychotics, anxiolytics, or mood stabilizers as prescribed by the psychiatrist to treat underlying mental health conditions (e.g., schizophrenia, depression - PDF point). Monitor for therapeutic effects and adverse reactions. Reason: To treat the underlying illness contributing to suicidality and alleviate distressing symptoms.

7. Encourage Expression of Feelings and Problem Solving: Provide opportunities for the patient to talk about their feelings (hopelessness, despair, anger, guilt). Help them identify stressors and explore alternative coping mechanisms and problem-solving strategies. (Taking therapy - PDF point). Reason: To reduce emotional distress and help the patient find healthier ways to deal with problems.

8. Involve Family and Support Systems (with patient consent): Educate family about the patient's condition, suicide risk, and how they can provide support. Assess family dynamics and support resources. Involve them in safety planning for discharge. Reason: Family support is crucial for recovery and preventing relapse.

9. Promote Engagement in Therapeutic Activities: Encourage participation in ward activities, group therapy, occupational therapy, or recreational therapy as appropriate and tolerated. (Recreational therapy, Occupational therapy - PDF points). Reason: To reduce isolation, provide distraction, improve mood, and develop coping skills.

10. Regular Reassessment and Documentation: Continuously reassess suicidal risk, mental status, and response to interventions. Document all assessments, interventions, patient statements, and changes in condition accurately and thoroughly. Reason: To ensure ongoing safety, adjust the care plan as needed, and maintain legal and professional accountability.

11. Multidisciplinary Team Collaboration: Work closely with psychiatrists, psychologists, social workers, and other team members to ensure a coordinated approach to care. (Involving a patient in multidisciplinary approaches - PDF point).

12. Discharge Planning and Follow-up: Begins early. Ensure a comprehensive discharge plan including follow-up appointments with mental health services, crisis contacts, medication management, continued safety planning, and support system engagement. (Rehabilitation by social workers, advice on discharge - PDF points). Reason: To ensure continuity of care and reduce risk of relapse after discharge.

## Question 2

## KABALE INSTITUTE OF HEALTH SCIENCE - NO.59

**- Define the term bi-pollar effective disorder. ( Bipolar Affective Disorder )**

**- State the signs and symptoms a person with bipolar effective disorder may present with.**

**- How would you manage a person with bipolar effective disorder in manic state?**

**ANSWER: Examination Script**

Bipolar Affective Disorder (often simply called Bipolar Disorder) is a chronic mental health condition characterized by extreme shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks. These shifts include episodes of intense excitement and energy (manic or hypomanic episodes) and episodes of depression. The PDF describes it as: "the mental disorder characterized by extreme excessive moods and extreme persistent lowering of moods for a period of more than two weeks."

Manic Episode Symptoms: A distinct period of abnormally and persistently elevated, expansive, or irritable mood, and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week (or any duration if hospitalization is necessary). Elevated/Expansive Mood: Feeling excessively happy, euphoric, "on top of the world." Irritability: Easily angered, agitated, or hostile. Decreased Need for Sleep: Feeling rested after only a few hours of sleep, or not sleeping for days. Grandiosity / Inflated Self-Esteem: Unrealistic belief in one's own abilities, importance, or power. Pressured Speech / More Talkative Than Usual: Rapid, loud, and difficult-to-interrupt speech. Flight of Ideas / Racing Thoughts: Thoughts jump rapidly from one topic to another. Distractibility: Attention easily drawn to unimportant or irrelevant external stimuli. Increased Goal-Directed Activity / Psychomotor Agitation: Excessive involvement in activities (social, work, sexual), restlessness, or purposeless movements. (PDF: "Increased psychomotor activities"). Excessive Involvement in Pleasurable Activities with High Potential for Painful Consequences: E.g., unrestrained buying sprees, foolish business investments, sexual indiscretions. (PDF: "Excessive involvement of pleasurable activities like excessive spending of money," "Excessive involvement in sexual activities with increased libido"). Psychotic Symptoms (in severe mania): Delusions (often grandiose or paranoid), hallucinations.

Hypomanic Episode Symptoms: Similar to manic symptoms but less severe, shorter duration (at least 4 consecutive days), and do not cause marked impairment in social or occupational functioning or require hospitalization. No psychotic features.

Depressive Episode Symptoms: A distinct period of depressed mood or loss of interest or pleasure in almost all activities, lasting at least 2 weeks. Depressed Mood: Feeling sad, empty, hopeless most of the day, nearly every day. (PDF: "Extreme sadness without a definite cause"). Loss of Interest or Pleasure (Anhedonia): Markedly diminished interest or pleasure in activities previously enjoyed. Significant Weight Loss/Gain or Decrease/Increase in Appetite. Insomnia or Hypersomnia (Disturbed sleep patterns - PDF point). Psychomotor Agitation or Retardation (observable by others). Fatigue or Loss of Energy. Feelings of Worthlessness or Excessive/Inappropriate Guilt. (PDF: "Feeling guilty"). Diminished Ability to Think or Concentrate, or Indecisiveness. (PDF: "Poor attention to orders given by him/her"). Recurrent Thoughts of Death, Suicidal Ideation, or Suicide Attempt. (PDF: "Suicidal attempts"). Increased Alcohol and Drug Abuse (can occur in any phase - PDF point). Inappropriate Dressing Code and Disorganized Behavior (can occur in mania or severe depression with psychosis - PDF point).

Mixed Episode (or Episode with Mixed Features): Symptoms of both mania/hypomania and depression occur simultaneously or alternate rapidly within a short period.

1. Ensure Safety (Patient and Others): Admit to a psychiatric ward/unit, preferably in a room with reduced stimuli (quiet, calm, not overly bright - as some patients are photophobic - PDF point). Remove potentially harmful objects from the environment to prevent self-harm or harm to others. (PDF: "room free from hazardous materials to prevent him/her from suicidal attempts"). If patient is very agitated, restless, and poses a risk, physical restraint may be necessary as a last resort, following strict protocols, for the shortest time possible. (PDF: "physical restraining can be done"). Close observation.

2. Pharmacological Management (as prescribed by doctor): Mood Stabilizers: E.g., Lithium, Valproic Acid (Sodium Valproate), Carbamazepine, Lamotrigine. These are the cornerstone of long-term treatment but also used acutely. Antipsychotics: Atypical antipsychotics (e.g., Olanzapine, Risperidone, Quetiapine, Aripiprazole) or sometimes typical antipsychotics (e.g., Haloperidol) are often used acutely to control agitation, psychotic symptoms, and reduce manic symptoms quickly. Benzodiazepines (e.g., Lorazepam, Clonazepam): May be used short-term for severe agitation, anxiety, or insomnia. (PDF: "Treatment may be administered as prescribed by the doctor").

3. Provide a Calm, Structured, and Low-Stimulus Environment: Reduce noise, bright lights, and excessive social interaction, as these can escalate mania. (PDF: "Ensure low stimulus of light since some patients are photophobic"). Maintain a consistent routine.

4. Establish Therapeutic Relationship: Use a calm, firm, consistent, and non-confrontational approach. Set clear, simple limits on behavior. Be empathetic but maintain professional boundaries. (PDF: "Establish therapeutic relationship between the patient and the caretakers").

5. Monitor Physical Health and Meet Basic Needs: Nutrition and Hydration: Patients in mania may neglect eating and drinking. Offer frequent, high-calorie, easy-to-eat finger foods and fluids. Monitor intake. (PDF: "Encourage a balanced diet to the patient e.g. finger foods"). Sleep and Rest: Mania often involves severely reduced sleep. Encourage rest periods. Minimize disturbances at night. (PDF: "Observe patients sleeping patterns and ensure enough rest by avoiding noise during the day and switching off lights at night"). Personal Hygiene: Assist with or encourage personal hygiene (bathing, grooming) as they may neglect self-care. (PDF: "Maintain personal hygiene of the patient since it is impossible for the patient to do self-care like bathing, combing hair"). Monitor vital signs.

6. Set Limits on Behavior: Clearly and consistently set limits on intrusive, demanding, or inappropriate behaviors in a non-punitive way. (PDF: "Allow the patient to have restricted movements under supervision" - implies limits).

7. Redirect Energy into Constructive Activities (if able to engage): Offer simple, non-competitive, short-duration activities that allow for release of energy without overstimulation (e.g., walking, simple chores, art).

8. Communication Strategies: Use short, clear, simple sentences. Listen to themes if speech is pressured or flight of ideas is present. Avoid arguing or trying to reason with grandiose or delusional ideas during acute mania. Focus on reality.

9. Monitor Mental Status and Behavior: Observe for changes in mood, thought processes, speech, behavior, sleep patterns, and response to medication. (PDF: "Observe the patients behaviors so as to be discharged when he or she is in at least normal moods").

10. Family Involvement and Education (when appropriate): Provide education to the family about bipolar disorder, the manic state, treatment, and how they can support the patient.

11. Discharge Planning (PDF points for "On discharge"): Health educate patient and caretakers on causes and prevention of mental illness (specifically bipolar disorder, medication adherence). Stress adherence to discharge drugs (mood stabilizers, etc.). Arrange when to return for follow-up clinics.

## Question 3

## BUTABIKA SCHOOL OF PSYCHIATRIC NURSING - NO.57

**- Outline 10 factors contributing to substance abuse in Uganda.**

**- Outline 10 measures that should be taken to prevent substance abuse among the youth and adolescents in your community.**

### ANSWER: Examination Script

1. Peer Pressure and Social Influence: Desire to fit in with peers, experimentation, or social acceptance within groups where substance use is common, especially among youth.

2. Unemployment and Poverty: Lack of job opportunities, economic hardship, and feelings of hopelessness can lead individuals to use substances as a coping mechanism or escape. Poverty may also drive involvement in drug trafficking or brewing illicit alcohol.

3. Stress, Trauma, and Mental Health Issues: Using substances to self-medicate or cope with stress, anxiety, depression, trauma (e.g., from conflict, domestic violence), or other underlying mental health disorders that are often undiagnosed or untreated.

4. Availability and Accessibility of Substances: Easy access to alcohol (including cheap, unregulated local brews), khat (miraa), marijuana, and increasingly, other illicit drugs like cocaine and heroin, especially in urban areas and border towns.

5. Lack of Awareness and Misinformation about Risks: Insufficient knowledge about the health, social, and legal consequences of substance abuse. Misconceptions that certain substances are harmless or enhance performance.

6. Family Factors: Family history of substance abuse (genetic predisposition and learned behavior). Poor parental supervision or monitoring. Dysfunctional family environments, domestic violence, parental neglect or absence. Parental substance use normalizing the behavior for children.

7. Weak Regulatory Frameworks and Law Enforcement: Gaps in laws regarding production, sale, and consumption of substances (especially local brews), and challenges in enforcing existing laws against illicit drugs.

8. Cultural and Social Norms: In some communities, alcohol consumption may be deeply ingrained in social events or traditions. Changing social norms and urbanization can also influence substance use patterns.

9. Media Influence and Advertising: Glamorization of alcohol or drug use in media, or aggressive marketing of alcoholic beverages, can influence attitudes and behaviors, particularly among young people.

10. Idleness and Lack of Recreational Facilities/Opportunities: Limited access to positive recreational activities, sports, or vocational training, especially for unemployed youth, can lead to boredom and experimentation with substances.

11. Urbanization and Social Dislocation: Rapid urbanization can lead to social stress, breakdown of traditional support systems, and increased exposure to diverse influences, including substance use.

12. School Dropouts / Lack of Education: Limited education and future prospects can contribute to a sense of hopelessness and vulnerability to substance abuse.

1. School-Based Prevention Programs: Implement evidence-based, age-appropriate drug education programs in schools that provide accurate information about substances, their risks, and develop life skills (e.g., decision-making, refusal skills, stress management).

2. Family Strengthening and Parenting Support Programs: Educate parents and caregivers on effective communication with adolescents, setting clear expectations and boundaries, monitoring, recognizing warning signs of substance use, and how to discuss substance abuse risks. Promote positive family relationships.

3. Community Awareness Campaigns: Launch public awareness campaigns using local media, community meetings, religious institutions, and cultural events to educate the entire community about the dangers of substance abuse and promote healthy lifestyles.

4. Provision of Youth-Friendly Recreational and Productive Activities: Increase access to positive alternative activities such as sports, arts, music, drama, youth clubs, vocational training, and mentorship programs to keep youth engaged and build skills.

5. Early Identification and Intervention for At-Risk Youth: Train teachers, community leaders, and healthcare workers to identify early signs of substance use or risk factors (e.g., mental health issues, family problems) and provide or refer for appropriate counseling and support.

6. Strengthening Regulation and Enforcement on Sale of Substances: Enforce laws against selling alcohol and tobacco to minors. Regulate the production and sale of local alcoholic brews to ensure safety and reduce potency/harmful additives. Strengthen law enforcement efforts against illicit drug trafficking and sale.

7. Peer Education and Support Programs: Train and support youth peer educators to deliver prevention messages and provide positive role modeling to their peers, as young people are often more receptive to messages from other youth.

8. Mental Health Support and Services: Improve access to mental health services for adolescents to address underlying issues like depression, anxiety, or trauma that may contribute to substance use as a coping mechanism. Integrate mental health into primary care and schools.

9. Life Skills Education: Incorporate life skills training (e.g., critical thinking, problem-solving, coping with stress, communication, assertiveness, refusal skills) into school curricula and youth programs.

10. Community Mobilization and Collaboration: Foster partnerships between schools, families, local leaders, religious organizations, healthcare providers, and NGOs to create a supportive community environment that actively discourages substance abuse and promotes youth well-being.

11. Role Modeling by Adults: Adults in the community, including parents and leaders, should model responsible behavior regarding substance use.

12. Reducing Stigma and Promoting Help-Seeking: Create an environment where young people feel safe to seek help for substance use problems without fear of judgment or punishment. Provide clear information on where to get confidential help.

### High-Yield Clinical Summary: Mental Health Questions and Answers

Clinical Section / Focus | Key Features & Exam Points | Nursing Management & Rationale

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