NURSING CARE STUDY

PATIENT NAME: E.K

WARD: MENTAL HEALTH UNIT

DATE COMMENCED: 01.05.2017

 BY

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HND/PSYCH/16003/017

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# IDENTIFICATION DATA

NAME: E.K

AGE: 30 YEARS

WARD: KENYA WARD

IP NO: 0361525

RESIDENCE: MEREWET

OCCUPATION: MASON

RELIGION: CHRISTIAN

DATE OF ADMISSION: 01.05.2017

# MODE OF ADMISSION

**Involuntary**

The patient came through out-patient department escorted by a nurse and the mother and the brother. The mother requested for admission by filling form MOH 614. The medical officer examined the patient and recommended the admission of the patient by filling MOH 615 in duplicate so the patient was admitted as an involuntary patient.

**Reasons for encounter**

* Talking a lot
* Violence
* Hearing voices
* Decreased need for sleep
* Wandering away from home
* Claim to receive powers from God

**Duration**

10 days

Onset: gradual

**History of presenting illness**

The patient has been well till 10 days ago when he started having decreased need for sleep, staying awake most of the night, he then started being violent and talking a lot claiming that he is hearing voices talking to him saying that God has given him power. No treatment was sought for the above

# PERSONAL HISTORY

Pregnancy and birth history

The mother claims that the pregnancy was term. There was no physical injury or disease in pregnancy. She claims that she did not take alcohol nor abuse drugs.

E.K was born in hospital via Spontaneous Vertex Delivery (SVD). She claims that the child cried immediately on delivery.

Early Childhood Experience

Mr. E.K stayed with his parents during his childhood and there was no separation from the mother. He suffered no physical trauma or illness affecting the central nervous system. He achieved his milestones normally.

The mother reports that E.K had no emotional disorder for example bedwetting and temper tantrums.

Educational History

Mr. E.K started school at the age of five years at Chebior Primary School. He then continued in the same school for his primary education. He repeated class 4 and class 8 to enable him improve his grades. He did his Kenya Certificate of Primary Education (KCPE) being a repeater in 2004 and scored 353 marks out of 500 marks.

He then proceeded to St.Patricks Iten from 2005 to 2008 and sat for Kenya Certificate of Secondary Education (KCSE) and scored C- (minus). He did not proceed to college because of lack of fees.

In school Mr. E.K related well with his peers and teachers. He also liked listening to music and playing football.

Occupational history

Currently Mr.E.K is a mason; he claims that masonry has a lot of money especially when you are awarded a contract. Mostly he gets approximately shs. 700 to 1000 in the job per day.

He also taught as an untrained primary school teacher in several schools.

The primary schools he taught are:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Primary School | Year | Monthly Pay |
| 1. | Lorimo Primary School | 2009 | Shs. 2000 |
| 2. | Itet Primary School | 2010 | Shs. 2500 |
| 3. | Koisu Primary School | 2011-2012 | Shs. 3000 |
| 4. | St.Patrick Junior Academy  | 2013 | Shs. 3500 |
| 5. | Katet Primary School | 2014-2015 | Shs. 3500 |

Patient claims that he shifted from one school to another looking for a better pay but while teaching Katet Primary School he was sacked due to alcoholism.

He claims that he had good relationship with coworkers and his seniors both when he was a teacher and now as a mason.

Social History

Mr. E.K is a social person. He claims to have several friends. He drinks alcohol especially spirits. He doesn’t smoke cigarettes. He is a Christian of Catholic faith but currently he doesn’t attend church. He does not have any social responsibility.

Pre-morbid personality

He is an extrovert and outgoing individual who is always optimistic towards life. He has very many friends of both sexes whom he relates well with. He spends his leisure time playing pool game and watching football.

Past psychiatric and medical history

Mr.E.K has been admitted to Mental Health Unit at Moi Teaching and Referral Hospital three times. Last admission was on 13/3/2015. He was treated for Bipolar Mood Disorder and was discharged on tabs haloperidol 10 mgs nocte and carbamazepine 400 mgs BD for one month.

Mr.E.K. has never been admitted to a medical ward or undergone any major surgery.

Marital and psychosexual history

Mr. E.K. is not married. Mr. E.K. reports to have had his first sexual encounter in form two. Currently he has no girlfriend. Initially he was in a relationship with a primary school teacher who they parted ways due to his psychiatric illness.

Family History

He is the 6th born in the family of 10 children. Both parents are alive and well. The father was a banker working with National Bank but was retrenched in the year 2008. Currently he is a farmer. The mother is a small scale peasant farmer.

Upon retirement in 2008 the farther married a second wife which brought tension in the family. The father has two children with the second wife and both families do not relate well. The relationship of the father and Mr. E.K. and other siblings of the first wife is poor. Also the parents don’t relate well.

Mr.E.K. relates well with his mother and other siblings. There is no sibling rivalry. There is a history of mental illness in the family. There is no history of epilepsy in the family. No history of alcoholism or substance abuse in the family. There is no reported painful recent event in the family.

The sibling history in chronological order

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| BIRTH POSITION | YEAR OF BIRTH | SEX | EDUCATION LEVEL | OCCUPATION | MARITAL STATUS | HEALTH STATUS |
| 1 | 1977 | MALE | FORM IV | MASON | SEPARATED | ALIVE AND WELL |
| 2 | 1979 | MALE | CERTIFICATE | AUTOMOTIVE | MARRIED | MENTAL PATIENT |
| 3 | 1981 | FEMALE | FORM IV | HAIRDRESSER | SEPARATED | ALIVE AND WELL |
| 4 | 1983 | MALE | COLLEGE | AUTOMOTIVE | MARRIED | ALIVE AND WELL |
| 5 | 1985 | MALE | UNIVERSITY | USAID/KENYAFARMER | MARRIED | ALIVE AND WELL |
| 6 | 1987 | PATIENT |  |  |  |  |
| 7 | 1989 | MALE | UNIVERSITY | UNEMPLOYED | SINGLE | ALIVE AND WELL |
| 8 | 1991 | FEMALE | COLLEGE | UNEMPLOYED | SINGLE | ALIVE AND WELL |
| 9 | 2001 | MALE | FORM II | STUDENT | SINGLE | ALIVE AND WELL |
| 10 | 2003 | FEMALE | FORM I | STUDENT | SINGLE | ALIVE AND WELL |

# MENTAL STATUS ASSESSMENT

**General appearance**

Personal hygiene - unkempt

Mode of dressing - appropriate

Mannerisms - absent

Ticks - absent

Facial expression - happy

Posture - upright while sited and standing

Gait - steady

Behavior - agitated

Body built - asthenic

Nutritional status - nourished

Rapport - established

Speech - coherent and pressurized

Mood - irritable

Affect - appropriate

Thought content – has delusions of religiosity, claims that he speaks to God

Thought process - has flight of ideas

Perceptual disorders- has auditory hallucinations claims that he occasionally hears voices

**Cognition**

Abstract reasoning - able to interpret a proverb “asiyekubali kushindwa si mshindani”

Judgment: good –says he could save a child from a burning house which has money also

Orientation:

Time- good – could tell that it was around 5 pm

 Place- good – knows that he was in a mental unit .

Person-good.knows that iam a medic.

Memory: Immediate- good –was able to remember that he took rice and beans for lunch

Recent-good– able to remember the recent Jubilee campaigns.

Remote- good –able to remember the first president of Kenya as Mzee Jomo Kenyatta

Insight – has no insight.

# PHYSICAL EXAMINATIONS

Head- normocephalic with well distributed black shaved hair

Eyes- symmetrical. No discharge noted in both eyes

Ears- hearing sense present and ear canal clean

Mouth – mucous membrane is moist. Teeth are cream-white in color and all present

Neck- thyroid gland present on swallowing

Upper limbs- equal in size with no deformity

Nails- short, clean capillary refill less than 3 seconds

Chest- respiration 20 beats/minute

Abdomen- soft and not tender

Genitals- voiding with no difficulties

Back- spinal cord complete and S- shaped

Lower limbs- equal in size with no deformity, edema or scars

**VITAL SIGNS**

Blood pressure – 110/60 mmHg

Pulse- 80 beats/minute

Respiration- 20 beats/minute

Temperature- 36.1oc

**PROVISIONAL DIAGNOSIS**: Bipolar Mood Disorder

Supportive data

* Talking a lot
* Claiming to receive powers from God
* Hearing voices
* Having flight of ideas
* Has no insight
* Has pressured speech
* He is irritable
* He is agitated

# BRIEF DESCRIPTION OF BIPOLAR MOOD DISORDER

**HISTORICAL BACKGROUND OF MOOD DISORDERS**

Mood disorders have been described for more than 40 centuries with ancient suffer including the biblical kings, Nebuchadnezzar, Saul, and Herod. Hippocrates (460-377 BC) hypnotized that black bile (melancholic) a toxic production of digestion caused depression. He may have posited the first biological theory of a cause for mood disorders

# DEFINATION

These are psychiatric illnesses characterized by abnormality of the mood involving mood alterations in form of extreme happiness (mania) or unusual sadness (depression). This is different from alteration of mood observed several times in response to events and circumstances in a normal person. Such fluctuations are usually normal because they are appropriate and understandable.

# PHYSIOPATHOLOGY

The pathophysiology of mood disorder is not understood. A variety of studies suggest the involvement of structural abnormalities in the amygdale, basal ganglia and prefrontal cortex. Research reveals that the disorder is associated with abnormal brain levels of serotonin, norepinephrine and dopamine.

The biochemical theories suggest that depressive disorder is due to abnormalities in monoamine transmitters at one or more sites of the brain. These transmitters include 5 hydrotriptamine 5-47 noradrenaline and norepinephrine. When these neurotransmitters are low in concentration, the individual suffers from the depressive illness and when they are high in concentration the individual suffers from mania.

Psychoanalytic theories view depression, guilt, decreased self-esteem and hopelessness. Sigmoid Freud described these concepts as mourning in which an individual tries to detach himself from a lost object and in the process the individual develops depression. Mourning is normal but can become pathological when one withdraws completely from the lost object without any energy attempts to new objects hence make the person experience low self-esteem.

The personality structure is involved whereby the ego fights the feelings operate from the primitive ID, the super ego intervenes and the person feels guilt are inverted towards introjections. Mania develops when this person tends to cover the low mood and low self-esteem he is experiencing by use of defense mechanism of projection. This disorder can be precipitated by environmental factors or any social factors which may be painful and stressful.

# ETIOLOGY

**Psychodynamics**

Psychoanalytical theory explains the cyclic behaviors of mania and depression as a response to conditional love from the primary caregiver. The child is maintained in a dependent position and ego development is disrupted. This gives way to the development of a punitive superego (anger turned inward or depression) or a strong id (uncontrollable impulsive behavior or mania). In the psychoanalytical model, mania is viewed as the mirror image of depression, a “denial of depression.”

**Genetics**

There is increasing evidence to indicate that genetics plays a strong role in the predisposition to bipolar disorder. Research suggests a combination of genes may create this predisposition. Incidence among relatives of affected individuals is higher than in the general population. Biochemically there appear to be increased levels of the biogenic amine norepinephrine in the brain, which may account for the increased activity of the manic individual.

**Family dynamics**

Object loss theory suggests that depressive illness occurs if the person is separated from or abandoned by a significant other during the first 6 months of life. The bonding process is interrupted and the child withdraws from people and the environment. Rejection by parents in childhood or spending a formative year with a family that sees life as hopeless and has a chronic expectation of failure makes it difficult for the individual to be optimistic. The mother may be distant and unloving, the father a less powerful person and the child expected to achieve high social and academic success.

**Hereditary**

Twin studies indicate that there is substantial genetic contribution as well as environmental influence. 0.71 of concordance rates in modern studies have been consistently estimated at around 40% in identical twins compared to 5% of fraternal twins and common among adopted twins as per studies done.

**Physiological**

Abnormalities in the structure and/or function of brain circuits could underlie bipolar disorder.

Meta-analysis of the structural MRI studies report an increase of the lateral ventricles Globus pallidus and increase in the rates of deep white matter hyper intensities.

**Environmental**

Evidence suggests that environmental factors play a significant role in development of bipolar disorder and individual psychosocial variables may interact with genetic predispositions. Recent life events and interpersonal relationships contribute to the likelihood of onsets of bipolar mood episodes. About 30%-50% of patients report traumatic/abusive experiences in childhood. Even with clear genetic factors altered health habits, alcohol or drug abuse or hormonal problems trigger an episode of bipolar mood disorder. If a person is vulnerable to bipolar disorder, stress, frequent use of stimulants or alcohol and certain medication of sleep may prompt onset of a depressive or manic episode.

**Neuroendocrinological**

Bipolar disorder is primarily a biological disorder that occurs in specific area of the brain and is due to the dysfunction of certain neurotransmitters like norepinephrine and serotonin and this may trigger external factors such as psychological stress and social circumstances. Dopamine known transmitter responsible for mood cycling has been shown to have increased transmission during the manic phase. Dopamine hypothesis states that the increase in dopamine results in secondary homeostatic down regulation of key systems and receptors such as an increase in dopamine meditated G protein coupled receptors hence increase in dopamine transmission characteristic of depressive phase.

# CLASSIFICATION OF MOOD DISORDERS

They are classified into two

1. Mania
2. Depression

**DEPRESSION PHASE**

This is a form of affective disorder characterized by low mood and sadness from which the individual cannot be easily destructed from. The mood is usually sustained.

**Clinical features for the depressive phase**

* The mood is always low
* There is lack of enjoyment
* There is reduced energy which leads to decreased withdrawal and occupational functioning
* There is neglected grooming
* The facial features are characterized by turning downwards
* The mood is that of misery and does not improve substantially in circumstances where ordinary feelings of sadness could be alleviated
* The shoulder are turned downwards
* The mood is often worse first thing in the morning when the patient wakes up, improving a little as the day wears on called diurnal variation of mood
* The behavior may be characterized by lack of interest and enjoyment in usual pleasurable activities
* The patient shows less enthusiasm in activities and hobbies that he used to enjoy and withdraws from social encounters
* There is reduced energy and the patient feels lethargic
* Finds everything an effort and leaves tasks unfinished
* Has psychomotor retardation frequently which is more in severe depression and the patient walks and acts slowly. Slowing thoughts are reflected in the patient’s speech that is reflected in a long delay before the patient can respond to the questions
* The patient is usually agitated and is manifested in a state of restlessness in which when the patient cannot sit in one place but moves up and down
* Irritability and anxiety is observed and the patient responds with annoyance to minor demands and frustrations

# CLASSIFICATION OF DEPRESSION

**Melancholia**

A form of psychotic (endogenous) depression associated with middle age (45-65 years). It is characterized by agitation and hypochondriacally symptoms (complaints of generalized nonexistent physical diseases)

It is believed that the etiology is the involution of sex glands and affects women more than men. Melancholia appears during the late 40s in women and late 50s in men when there are extensive changes in the body which have psychological significance e.g. anticipated loss of sexual attractiveness.

**Etiological classification**

Endogenous vs. reactive – exogenous

Symptom pattern classification

Psychotic vs. neurotic

Degree of severity pattern of classification

Major/severe vs. minor/mild

# COMPARE AND CONTRAST ENDOGENOUS/PSYCHOTIC/MAJOR AND REACTIVE EXOGENOUS NEUROTIC/MINOR DEPRESSION MILD DEPRESSION

## Etiology

**Endogenous/reactive depression**

Symptoms of endogenous depression are caused by factors within the individual and independent of outside factors example is genetic constitutional factors. Symptoms seem to rise out of the blues with no clear external precipitation though external stresses can provoke or sustain the illness and the relationship is less justifiable for it may follow a trivial incidence. The symptoms of reactive exogenous depression are as a response to the external stressors like the reaction to losses. The magnitude of the stressful factors is justifiable.

## SIGNS AND SYMPTOMS

Anxiety symptoms are more common in neurotic depression while psychotic symptoms are more common in psychotic depression. Early morning wakening is seen in psychotic depression. In psychotic depression the mood is persistently low and undistractable while in neurotic depression the mood fluctuates in line with the environment. Diurnal mood variation in psychotic depression the sufferer tends to be at his worst in the morning and improves as the day progresses while in neurotic depression the reverse tends to be the case with worsening as the days goes on, this can be explained by the fact that neurotic depressive mood can be pleasant environment meaning that the sufferer can be distracted from his misery by a pleasant situation. This is why a neurotic depressed patient feels worse at the end of the day when he/she is alone and better at the beginning of the day when he/she is with other people. Hypochondriasis is more common in neurotic depression the somatic complaints are multiple and may vary from day to day and affects different systems of the body and are paraded in an attention seeking manner, while in psychotic depression hypochondria usually focuses on one organ or system and are consistently held e.g. the patient may actually believe that he has cancer and is going to die. In neurotic depression the sufferer tends to blame other for his predicament than himself as seen in psychotic depression. Suicidal thoughts and suicide is common in psychotic depression and while suicidal thought may be present in neurotic depression, suicide is rare.

The following features only occur in psychotic type of depression:

**Delusions**: alongside with hypochondriac ideas the patient may have delusions of guilt, worthlessness,nihilistic or poverty.

**Hallucinations**: hallucinations when present are keeping with the depressive affect the patient may have auditory hallucinations of various types mocking him and plotting against him or olfactory hallucinations perceiving foul smell emanating from his body.if visual hallucinations, he sees death scenes and destructions

**Retardation**: slowness of mental as well as motor activity tends to occur only in psychotic depression

**Appetite**: the appetite in psychotic depression is poor resulting to weight loss but in neurotic depression appetite is not lost

**History**

**Previous psychiatric history**

The patient with psychotic depression might give a history of previous similar depression or mania. The neurotic depressive is likely to give a history of several depressive episodes with no attack and always precipitates by external understandable stress (unipolar depression). There may be a history of previous avert anxiety disorder e.g. anxiety state, obsessional neurosis or hysterical behavior in the neurotic depression.

**Family history**

There may be evidence of psychiatric history in the family of psychotic depression.

**Premorbid personality history**

The patient with psychotic depression may have a cyclothymic depression. May have a clothymic mood or hypothymic one. The neurotic depression tends to have a vulnerable or inadequate type of personality.

# DEPRESSIVE STUPOR

This is the most severe type of depression. It is characterized by feelings of total despair, hopelessness and worthlessness, feeling of nothingness and emptiness, apathy, loneliness, sadness and inability to feel pleasure. Severe psychomotor retardation which is so severe that physical movement may come to a standstill bits in curled up position. Because of the low energy level and related thought process the individual may be able to follow on suicidal ideas, however the desire is strong at this level. Physiologically, the general slowdown of the entire body leads to sluggish digestion, constipation and urinary detention, amenorrhea, impotence, diminished libido, anorexia, weight loss, difficulty falling asleep and awakening very early in the morning.

**Etiology**

**Genetics**

Research has revealed relevance of hereditary factors in causation of depression, twin studies suggest a genetic factor in the illness because 50% of monozygotic twins are concordant for the illness (concordant refers to twins who are both affected with the illness) even if they are raised apart in different environments

**Family studies**: most family studies have shown that major depression is more common among first degree biological relatives of people with the disorder relatives than among the general population

**Adoption studies**: have shown that the biological children of the affected parents remain at increased risk of a mood disorder (depression) even if they are reared in non-affected families.

**Biochemical influence**

It has been hypothesized that depressive illness may be related to deficiency of the neurotransmitters norepinephrine, serotonin and dopamine at important receptor sites in the brain. This hypothesis grew out of the observation that reserpine which depletes the brain of amines was associated with the development of depressive symptoms. Diminished supplies of these neurotransmitters inhibit the transmission of impulses from one neuronal fiber to another causing a failure of the cells to fire or become charged.

**Endocrine disturbances**

May play a role in the persistence of depressive illness. This notion has risen in view of the marked disturbance in mood observed with the administration of certain hormones. In clients who are depressed the normal system of hormonal inhibition fails resulting in hyper secretion of cortical leading to depressive symptoms.

**Neurological disorder**

Brain tumors particularly in the areas of the temporal lobe often cause symptoms of depression. Agitated depression may be part of the clinical picture associated with Alzheimer’s disease, Parkinson’s disease and Hennington’s chorea. Agitation and restlessness may also represent an underlying depression in the individual with multiple sclerosis.

 **Electrolyte disturbances**

Excessive levels of sodium bicarbonate or calcium can produce symptoms of depression as can deficit in magnesium and sodium. Excess of potassium in the body have also been observed to cause depressive symptoms as well as in instance of potassium depletion estrogen-to-progesterone ration during the initial phase of the menstrual cycles is responsible for the symptoms associated with premenstrual syndrome.

**Nutritional deficiencies**

Deficiencies in B vitamins, vitamin C, and potassium may produce symptoms of depression

**Physical disease**: some diseases are painful and stressing and may lead to depression e.g. terminal illness

**Psychoanalytic theory**

Freud observed that depression occurs after the loss of a loved one or object. He indicated that in depression the person’s rage is internally directed because of identification with the lost object

**Learned helplessness**

Helplessness exists in a person who has experienced numerous failures. The individual abandons any further attempts to succeed and lacks control over his/her life situation. They become depressed because they feel helpless; they have learned that whatever they do is futile. This can be damaging especially very early in life because the sense of mastery over ones environment is an important foundation for future emotional development and could be a symptom rather than a causative factor.

**Physique and personality**

Persons of picnic body build are particularly more to affective illness

**Cyclothymic personality**

People with repeated and sustained mood swings are more prone to develop manic depressive disorder

**Environmental factors**

Early childhood experiences, mental deprivation and childhood deprivation of maternal affection through separation or loss predisposes to depressive disorder in adult life. The theory of object loss suggests that depression occurs as a result of having been abandoned by or otherwise separated from a significant other during the first six months of life, because this period the mother represents the child main source of security, she is the object. The response occurs not only with a physical loss but this absence of attachment may be either physical or emotional, leads to feelings of hopelessness and despair that contribute to lifelong pattern of depression in response to loss.

Maternal deprivation which results from this separation includes behavior such as excessive crying, anorexia, withdrawal ,psychomotor retardation, stupor and a generalized impairment in the normal process of growth and development.

**Life events**

It has been found out that depressive disorders by psychotropic mechanism often follows stressful events like various types of losses, demanding events, pressures of living, dysfunctional marital relationships leading to divorce or separation and socio-economic factors periods of extreme poverty.

# PSYCHOPATHOLOGY

**Biological Basis**: the alteration of affective disorders by psychotropic mechanism leaves no doubt that these disorders have a significant biological basis e.g. the catalytic action of enzymes, monoamine oxidase in the brain and its association with depressed emotional status.

**Psychoanalytic theory**

View depression as behavioral expression of one or several disturbed core concepts; these behavioral expressions include hospitality, oppression, guilt ambivalence, decreased self-esteem, hopelessness and helplessness. Freud described it as mourning and that it is a process initiated by a loss and involving detachment from the lost object with resentment of energy into an object that eventually replaces the one that was lost. He describes this process as normal one that does not involve a loss of self-esteem but he regarded melancholia as a pathological process in which the individual withdraws from the valued object and demonstrates a marked decrease in self-esteem.

The loss evokes hostile and aggressive impulses which arise from unconsciousness, these feelings conflicts with ego responses which are more positive. The punitive super ego enters to intervene in the ID impulses. When this psychic battle rages between ID and super ego the patient experiences guilt and self-depreciation, hostile and aggressive feelings are turned inwards and vented to self. In a manner the individual tries to cover up their low self-esteem by utilizing the defense mechanism of projection and projects a lot to others.

His anxiety hostility and guilt is a way of solving problems he may be boastful, aggressive, and hyperactive to cope with his anxiety. He appears unhappy to cope with painful situations in his conscious hence masking depression. The disease is precipitated by some deep personal traumatic loss and projects to the person/object within the environment. He appears boastful quite demanding sarcastic, hostile overactive, violent and determination.

# MANAGEMENT

**PHYSICAL TREATMENT**

**CHEMOTHERAPY**

Not necessary for mild depression which is a result of environmental stress and crisis. This tends to resolve spontaneously with simple supportive treatment but a persistent low mood from which the patient cannot be distracted together with somatic features (early morning wakening and diurnal mood variation and loss of weight or appetite) suggests that a good response to drug is expected.

**Antidepressants**

These are used to raise patient’s low mood and hence the patient may see himself worthy living. Drugs used are:-

Tricyclic: first line of chemotherapy their mode of action relates to the amine hypothesis. They act by preventing the reputable neurotransmitters (amines) at the neuron. Since the onset of their effects is slow they should be taken 5-6 weeks before course of treatment is said to be affective. They are very dangerous in over dosage and maximum caution should be taken when administered to suicidal patients. They should be prescribed with caution to to the elderly people as normal dosage for a young adult would prove to be toxic in an older person and observe depressive mood changes into mania.

Tricyclics included in the treatment of depression are: amitriptyline (laroxyl). It has a sedative effect so it is helpful in inducing sleep and relieving of agitation if present.

**Monoamine oxidase inhibitors (MAOIS)**

Indicated for resistant depression to the first line of treatment and rarely used because of their side effects. They act differently compared to the other antidepressants, instead of blocking reuptake of neurotransmitter, they block the activity of Mono amine oxidase an enzyme that breaks down the neurotransmitters. They interact dangerously with certain drugs and food stuffs that contain tyramine e.g. certain wines, cheese, yeast extracts and smoked fish. Drug containing sympathomimetric amures are available without prescriptions and include antihistamines cold remedial and cough mixtures. MAOI may also interact dangerously with alcohol, barbiturates, and hypertensive drugs like methyldopa. This interaction initiates hypertensive crises characterized by occipital headache which may radiate frontally, palpitations, neck stiffness, nausea, vomiting, sweating, dilated pupils, pholephobis, tachycardia or bradycardia, chest pain and possible cerebral hemorrhage.

Selective serotonin reuptake inhibitors (SSRI)

Example fluoxetine 20 mg once daily. It is same as tricyclic but safer in side effects and overdose.

**ELECTRO CONVULSIVE THERAPY (ECT)**

Recommended for severe depression especially those with marked weight loss, suicidal ideas and psychomotor retardation, depressive stupor and somatic features, depressive delusions, failure to respond or comply with drugs. Exactly how ECT works remains unclear but the seizure most likely modifies the chemical environment of neurotransmitters. It increases the sensitivity of synaptic monoamine receptors in the brain.

# NURSING CARE

In the acute phase one to one interaction is recommended before the patient is introduced to a wider scope of interpersonal social relationship. As the patient progresses he/she is introduced into group therapy and raises the patient self-esteem realistically through acceptance. The nurse should provide a therapeutic environment, safe and supportive. If suicidal ideas are present enough precaution should be taken to prevent suicide including printing a suicidal caution card whereby patient’s behavior is closely monitored. The nurse should avail self to the patient so that he can feel accepted and this may assist in abolishing feelings of worthlessness and the patient should be talked to even if he/she is mute.

Suitable recreational activities should be provided so that the patient may not be preoccupied with suicidal ideas. The nurse should nurse the patient in a quite comfortable environmental. The patient should be introduced to simple non challenging activities and encouraged to groom him/herself, this will contribute to the self-esteem. The nurse should avoid behaviors that will confirm ideas or delusions of worthlessness and convey attitude of caring verbally or non-verbally. Patient’s physical needs should be met by providing with small amounts of attractive foods. For severe one put an output and input chart and if completely unable to feed put on nasal gastric tube for feeding. Personal hygiene should be supervised and assist the patient to have a bath and change into clean clothes. Encourage hygiene by rewarding the patient positively on any move he/she makes towards grooming.

Good sleep should be provided in a warm and quiet environment and the sleep patterns are observed. A mental assessment should be performed to assess the progress of the patient. Occupational therapy should be done since it helps in diversion of patient’s mind from delusions and hallucinations this prevents further deterioration of patient’s illness and it stimulates interest as well as raises self-esteem through the feeling of doing something useful and pride in achievement. It also diverts the patient’s attention from himself onto the other things and offers retaining in areas where the skills have been diminished.

Group therapy should be done because nursing care is aimed at helping the patient cope up with his problem, find solutions to his problems and continue performing his normal responsibilities. The social worker should be involved if there is psychosocial problem precipitating or perpetuating the illness. Family and marital psychoeducation intervention increases clinical stability and reduces hospitalization as well as having other functional and psychosocial benefits. This education involves the nature of the illness; the role they play in the management of the patient; health message on drug compliance; clinic attendance.

Home visits before discharge should be done to assess patient’s environment and support systems and resources available for the patient. The patient’s employer should be involved to provide needed support and understand the patient’s condition.

# MANIA

Symptoms of mania may be a progression in intensification in a hypomania or they may be manifested directly. Most individuals experience marked impairment in functioning and require hospitalization.

**CLINICAL PRESENTATION OF MANIA**

**Speech**

The speech is rapid commonly described as pressure of speech

**Thought process**

Thoughts are crowded into the patient’s mind and race in quick succession leading to flight of ideas (has no time to waste on one particular thought). This makes it difficult for a listener to understand the conversation.

**Behavior**

Psychomotor activity is excessive and this is displayed socially and sexually uninhibited behavior (sexual interest is increased) and reduces sexual control. Women sometimes neglect precaution against pregnancy expansive ideas. The patient becomes extravagant and may over spend within a short duration. Delusions of grandeur that may be accompanied by delusions of persecution are very common. More often the patient becomes very manipulative and may mislead people to do the wrong things

**Insight**

Most bipolar patients lack insight

**Motor activity**

Manic patient is overactive, over talkative. This may lead to physical exhaustion. The patient may start many activities but leave them unfinished as he ventures into new activities.

**General appearance**

Patient’s clothing often reflects his elated mood as he dresses in bright colors and ill-assorted choice of garments. Females display excessive amounts of poor applied make ups and their hygiene and grooming is neglected.

**Sleep patterns**

The patient remains sleepless. Sleeps late and wakes up early often feeling lively and energetic. They have no time to waste in sleep and may go for many days sleep and still not feel tired.

**Appetite**

Has increased appetite but in severe cases he doesn’t eat as he is busy with other uncoordinated activities. He is too active or too busy to have time to feed.

**Hallucinations**

If hallucinations occur they are usually consistent with the mood e.g. auditory hallucinations in form of voices speaking to the patient about his special powers or occasionally of visions with a religious content.

**Attention and concentration**

Manic patients are highly distractible with poor powers of concentration. A line of conversation may suddenly switch to commenting about the environment.

**Judgment**

Poor because they are not critical

**DELIRIOUS MANIA**

This is a severe form of mania. A grave form of the disorder characterized by severe clouding of consciousness and intensification of the symptoms associated with acute mania. This condition has become rare since the availability of anti-psychotic medication. The mood of the delirious person is very labile. He/she may exhibit feelings of despair, quickly converting to unrestrained ecstasy or becoming irritable which may lead to aggressive and violent behavior. The psychomotor activity is characterized by agitated, purposeless movements and safety of the patient is at stake unless this activity is curtailed. Exhaustion, injury to self or others and eventually death could occur without intervention. The thinking is incoherent, delusions become increasingly bizarre.

# MANAGEMENT OF MANIA

In all but the mildest cases of mania, admission to hospital is always necessary to protect the patient from the consequences of his own behavior (recklessness and disinhibition). The immediate treatment is aimed at controlling the mood and abolishing the psychotic features

**Chemotherapy**

Several antipsychotic medications have been approved. These include:

**Typical antipsychotics**

These are traditional drugs and include:-

**Chlorpromazine (largarctil)**

Chlorpromazine is a more sedating alternative 100- 200 mgs three times daily where mood and psychomotor activities are acutely elevated; first dose may need to be given intramuscular. Fluphenazine deaconate is administered as long term treatment. The treatment is recommended for patients who have difficulties in drug compliance.

**Anticonvulsants/ mood stabilizers**

**Lithium**

Classic mood stabilizer and is recommended for acute mania and maintenance therapy to prevent or diminish the intensity of subsequent manic episodes. The therapeutic level of lithium is 1.0-1.5 mEq/l

Carbamazepine is used for acute mania and is prophylaxis for bipolar mood disorders and it has been found effective in clients unresponsive to lithium.

**Electro convulsive therapy**

Episodes of acute mania are occasionally treated with electroconvulsive therapy particularly when the client does not tolerate or fails to respond to lithium or other drug treatment or when life is threatened by dangerous behavior or exhaustion.

# NURSING CARE

The primary aim is at controlling over activity. The nurse should portray calmness when dealing with a manic patient. During acute phases avoiding involving manic patients in very stimulative activities e.g. dancing or singing hymns, leading other patients in prayer. The nurse should encourage the patient to sleep even during the day. Irritable and aggressive outbursts should be controlled using minimum confrontation and physical restraining and avoiding provocation hence the importance self-control and patience.

The nurse should channel the patient’s excessive energy toward safer activity and identify and remove any factors that would stimulate his activity. Angry confrontation should be avoided which often arise because the patient makes unreasonable demands that cannot be met (this can be achieved if his demand that cannot be met is assumed until his attention turns to another topic that he can be encouraged to pursue). Performance of mental status assessment is done to judge his progress and also to identify her needs and problems and act accordingly.

Manic patients are very manipulative so set limits to his demands and the nurse should be firm and consistent and also accept the patient behavior as originating from his illness other than condemning him.

The nurse should avoid being judgmental, listen carefully and assist the patient to see reality. Delusions should not be reinforced and patient’s personal hygiene should be supervised on bathing and dressing since he is too busy with other uncoordinated activities that he cannot groom himself. Feeding should be supervised and ensure that he finishes his meals also intake of plenty of oral fluids should be encouraged as he is likely to get dehydrated due to physical exhaustion. The nurse should provide a therapeutic environment free of objects that he may use to hurt others in the environment or himself or objects that may stimulate activities. A careful watch should be kept for symptoms of depression. The patient is then introduced to group therapy when the mood is controlled e.g. to improve his concentration and listening skills and give him appropriate role. Introduction to occupational therapy to get involved in activities that would channel his excessive energy in a socially acceptable manner e.g. football and it also helps in diversion of patient’s mind from hallucinations and delusions. A home visit should be done especially to identify any environmental factors that may be contributing to his illness and give health education accordingly.

The family members should be educated on the causes, course and treatment of the illness, their role in the management of the patient and if employed give guidance to the employer concerning patient’s condition so as to eradicate stigma and prevent dismissal on the ground of mental illness. The family and the patient should identify the community resources that the patient will utilize to prevent a relapse and maintain his health like religious institutions, organized groups.

# MANAGEMENT DURING HOSPITALIZATION

The patient was admitted on 01/05/2017, the legal forms filled in duplicate. A mental status assessment and physical examination was done. Blood slide for malaria parasite was taken which was negative. The vital signs were also within the normal ranges. The patient was also involved in group and individual therapy while in the ward.

Drugs administered include tablets haloperidol 10mgs twice daily, clophixol acuphase 200mgs weekly and carbamazepine 200mgs twice daily.

# NOTES ON DRUG USED

**Carbamazepine**

**Classification**

A mood stabilizer. It is a versatile antiepileptic agent with psychotropic properties.

**Mode of action**

As an anticonvulsant, it acts by reducing postsynaptic responses and blocking the post-tetanic potentiation which results from the drugs ability to limit repetitive firing of potential by a sustained depolarization of neurons

**Dosage**

Adults 200mgs twice daily (400mgs per day)

**Indications**

Complex partial seizures, generalized tonic clonic seizures, pain in trigeminal, ghassopharyngeal and post hepatic neuroglia. It is also used in pain in diabetic neuropathy mania. Schizoaffective disorder, alcohol withdrawal syndrome and migraine prophylaxis

**Contraindication**

Hypersensitivity to carbamazepine, known sensitivity to tricyclic antidepressants like amitriptyline, history of bone marrow depression and concurrent use with mono amine oxidase inhibitors.

**Adverse effects**

Drowsiness, dizziness, vertigo, ataxia, diplopia, blurred vision, nausea, vomiting and hypersensitivity reactions.

**Drug interaction**

Phenobarbitone, phyenytoin and valproic acid may increase the metabolism of carbamazepine. Carbamazepine reduces the plasma concentration and therapeutic effects of haloperidol and propoxyplene and erythromycin may block the metabolism of carbamazepine.

**Nursing interventions**

Monitor for the following reactions which commonly occur during early therapy; drowsiness, dizziness, light-headedness, ataxia and gastric upset

Continuous electrocardiogram monitoring for 24 hours for patients who experience an apparent increase in frequency of seizures this is because cardiac syncope may resemble epileptic seizure. Withhold the drug and notify physician if any signs of myelosuppression occur, RB<4mm/million, HCT<32%, Hgb<11gm/dl, WBC<400mm3 and platelets<100,000/mm3

**HALOPERIDOL**

It is a typical antipsychotic

**Indications**

Treatment of psychosis, tourettes disorder and severe behavioral problems in children. It is also used for emergency sedation of severely agitated or delirious patients and amphetamine related psychosis.

**Contraindications**

Hypersensitivity to haloperidol, narrow-angle glaucoma and Parkinsonism

**Mode of action**

Competitive blockage of postsynaptic dopamine receptors in the mesolimbic dopaminergic system hence blocking the activity of dopamine in the brain reducing psychotic symptoms

**Drug interaction**

Decreased effect with carbamazepine, phenobarbitone. There is increased toxicity with central nervous system and depressed lithium and anticholinergic

**Precautions**

Use with caution in patients with cardiovascular diseases or seizures

**Dosage**

Adults 0.5mgs 2-3 times per day to a maximum of 5 mgs 2-3 times per day.

**Over dosage/toxicology**

Symptoms include deep sleep, dystonia, agitation, dysrhythmias, and extrapyramidal symptoms

**Side effects**

Parkinsonian extra pyramidal effects, swelling of breasts, weight gain, blurred vision, nausea, vomiting, photosensitivity, agronulocytosis, heart stroke, obstructive jaundice, gastrointestinal upsets, dry mouth and leukopenia.

**Nursing interventions**

Observe for seizures, use with caution in patients with pre-existing seizures disorders as haloperidol decreases seizures threshold. Adverse reactions like hypotension should be monitored, cardiovascular changes like tachycardia should be monitored. Haloperidol should be used with caution in elderly patients as they develop tardive dyskinesia hence a lower dose is given. Monitor for anticholinergic side effects such as dry mouth, constipation and urinary retention.

**Clophixol acuphase/zuclopenthixol**

 It is a depot preparation of a long acting antipsychotic

**Dosage**

200mgs interval of 1-4 weeks

**Indication**

Schizophrenia, mania and patient with poor drug compliance

**Mode of action**

Competitive blockage of postsynaptic dopamine receptors in the mesolimbic dopaminergic system reducing psychotic symptoms.

**Contraindications**

Hypersensitivity to zuclopenthixol, diminished consciousness

**Caution**

Patients with liver dysfunction, history of convulsions or fits, diabetes, organic brain syndrome and cardiovascular disorders

**Drug interaction**

Tricyclic antidepressants, barbiturates, anticholinergic and clophixol depot increase sedative effect of alcohol making the patient drowsier

**Side effects**

Parkinsonian extra pyramidal side effects, swelling of breasts, weight gain, blurred vision, nausea, vomiting, photosensitivity, agronulocytosis, heart stroke, obstructive jaundice, gastrointestinal upsets, dry mouth and leukopenia

**Nursing intervention**

Observe for seizures, use with caution in patients with pre-existing seizures disorders as haloperidol decreases seizures threshold. Adverse reactions like hypotension should be monitored, cardiovascular changes like tachycardia should be monitored. Haloperidol should be used with caution in elderly patients as they develop tardive dyskinesia hence a lower dose is given. Monitor for anticholinergic side effects such as dry mouth, constipation and urinary retention.

The drugs that were given to the patient while in the above produced the desired effects as the patient improved greatly and made the recovery faster. Within the first two weeks there were tremendous changes as the aggressive behavior was no longer there. There were no extra pyramidal side effects observed at the course of the treatment.

# A SAMPLE OF NURSING CARE PLAN

NAME:…………………………………E.K

AGE:…………………………………...30 YEARS

SEX:…………………………………...MALE

DIAGNOSIS:…………………………BIPOLAR MOOD DISORDER

DATE:……………………………….04/05/2017

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Assessment | Goals/expected outcome criteria | Nursing intervention/ plan of care | Rationale  | Implementation  | Evaluation  | Name  |
| Poor personal hygiene | To enable the patient to be comfortable | Assist the patient to bath.Provide hospital uniform | To provide comfort and increase patient’s self esteem | Patient was assisted to take a bathPatient was given hospital uniform | Fully met | Buturu |
| Patient drowsy during the day | To ensure that the patients get enough sleep | Administration of antipsychotics | To produce sedative effects and allow the patient to sleep and eradicate hallucination | The patient was given tablets haloperidol at 3pm by buturu | ongoing | Buturu |
| hyperactivity | To prevent the patient from getting injury to self and others | All dangerous objects are removed from the environment, engaging patient in psychotherapeutic group activity | To create a therapeutic environment free from injury | Patient is involved in group activity by the student nurses and all hazardous items locked in the store | The patient was able to settle down and got engaged in group activity | Buturu |

#  A SAMPLE OF AN INTERACTION SESSION

NAME: E.K

DIAGNOSIS: BIPOLAR MOOD DISORDER

VENUE: MENTAL HEALTH UNIT- MALE SIDE

WARD: MENTAL HEALTH UNIT

IP NO: 0361525 DURATION: 2O MINUTES

DATE: 08/05/2017 TIME: 11:00 AM

OBJECTIVE: IMPORTANCE OF TAKING DRUGS AS PRESCRIBED

|  |  |  |
| --- | --- | --- |
| THERAPIST | PATIENT’S RESPONSE | REMARKS |
| Hi? How are you today?Welcome to today’s discussion | Hi I am fine. Thank you | The patient was sitted and calm |
| Today as we talked yesterday we are going to discuss the importance of taking your drugs. Why do you think it’s good to take your drugs as prescribed? | I think I should take my drugs while in the hospital but if I am well I don’t see the reason why I should continue taking drugs | The patient was not seeing the need to take drugs after discharge |
| Last time did you take your drugs after discharge? That was why your illness came back. If you could take your drugs as prescribed you could be continuing with your work as a mason | No I did not. Sure? Will I not come back for admission? If that is the case I will take them as you say | The patient was able to understand the importance of drug compliance |
| Thank you so much for your time. Please take your drugs as prescribed whether at home or in the hospital, tomorrow we will discuss on the importance of attending your follow up | Thank you too I will follow what we have discussed | The patient remained calm. The patient needs more discussion on importance of taking drugs which will be done during the next interaction session |

# PREPARATION FOR DISCHARGE

After assessing the patient it was found that he had shown marked improvement. A mental status assessment was done and the findings were as below

**MENTAL STATUS ASSESSMENT ON 16/05/2017**

**General appearance**

Personal hygiene………………………………. Kempt

Mode of dressing……………………………… Appropriate (uniform)

Mannerism…………………………………….. Absent

Ticks…………………………………………... Absent

Facial expression……………………………... Happy

Posture………………………………………... Upright while sitted and standing

Gait…………………………………………… Steady

Behavior……………………………………… Calm

Body built…………………………………….. Athletic

Nutrition……………………………………… Well nourished

Rapport……………………………………….. Established and maintained

Speech………………………………………... Coherent

Mood…………………………………………. Euphoric

Affect………………………………………… Appropriate

Thought content…………………………….. There were no delusions and suicidal thoughts

Thought process…………………………….. No thought block, thought withdrawal and no flight of ideas

Perceptual disorder………………………… There were no hallucinations or illusions

**COGNITION**

**Abstract reasoning** :- Good. He was asked what- “ pole pole ndiyo mwendo,” meant and he said (ukichukuwa muda kufanya kitu matokeo ni mazuri)

**Judgment** :- good he was asked what he could do if he won 100 million. He said he would register a company and get contracts to build houses

**Orientation** :- good in terms of time, place and person (could tell the estimate of time well, knew where he is and knew who the people he was talking to were)

**Memory** :

Immediate :- good ,was able to remember that we were medics as he was asked

Recent :- good, he was able to remember that he took porridge for breakfast; it was confirmed by the nurse in charge of patient’s feeding

Remote :- good as he was able to remember the first president of Kenya as Mzee Jomo Kenyatta

**Concentration** :- good, he was able to count from 100 downwards considering his education level

**Insight** :- presently the patient is aware that he is mentally sick and wants to take medication

The patient was presented to a doctor’s ward round and after assessment he was discharged on haloperidol 10mgs twice daily, carbamazepine 200mgs twice daily and given a return date of one month at the psychiatric outpatient clinic.

# FIRST HOME VISITING DONE ON 12/05/2017

**OBJECTIVES**

1. Find out availability of support in the family and community
2. Identify the community resources the patient may use to influence his mental health positively
3. Identify the environmental factors arising from the family that may have caused mental illness

We left for Mr.E.K’s home with him accompanied by his brother and my classmate Cosmas. We boarded a private vehicle at 11.00 am and arrived at 11.45 am. We were welcomed by the mother, two brothers and a sister. With them also was an uncle and two members of the local church. They live in Merewet in Ziwa, Uasin Gishu county. They live in 10 actres piece of land. The mother lives in a three-roomed house with a kitchen. They have a borehole which they draw water both for domestic use and for use by the domestic animals. They also have a pit latrine about 100 meters from the mother’s house. Mr.E.K has also built for himself a semi-permanent house, a sloped house roofed with six iron sheets. The mother has three dairy cows which give her milk which she sells to milk vendors for some cash. She also plants maize in 2 actres of land. The other three brothers have also built their houses in different parts of the farm and each of them has been given one actre piece. At his house, Mr.E.K was able to show us his tools of trade.

The nearest health facility is Merewet dispensary which approximately one kilometer from the homestead. There is also St.Mary’s Lorwo Catholic Church which is around 500 meters from his home. Lorwo primary school is about one kilometer from the homestead. There is also a shopping center which has a bar, according to the mother Mr.E.K occasionally drinks in the bar and forgets to swallow his medication thus leading to readmission. We encouraged him to stop occasional drinking and he promised to stop it and concentrate on his work.

We terminated our visit and thanked the family members for welcoming us. We also informed them that we will make another visit after the discharge of Mr.E.K. we left the homestead at 3.30pm.

# SECOND HOME VISIT ON 19/05/017

**OBJECTIVES**

1. To evaluate the objectives of the first visit
2. To assess drug compliance and any possible side effects
3. To educate the family on the causes, treatment and triggering factors of the condition their patient is suffering from

I left for the second home visit accompanied by Cosmas my classmate at 2.00 pm. We arrived safely and found all members waiting including Mr.E.K. We were offered a warm welcome. The meeting started with a word of prayer from Mr.E.K’s mother. Mr.E.K was very happy to see us and said he was ready to go back to his duties of masonry. The mother reported that Mr.E.K was taking his drugs as prescribed and there were no side effects observed. We also established that the family was so supportive towards his recovery and were willing to help him resume his activities of earning a living. We asked them about the return date for follow up and they said it was due in two weeks time on a Wednesday which was true as confirmed by the card. We counted the drugs against the number issued and they were tallying indicating proper drug compliance as the mother attested to it. We taught him the importance of taking the drugs and attending his appointments. Finally we educated the family on the causes of the illness, prevention, treatment and some triggering factors. Having exhausted our objectives we thanked the family and left the homestead at around 4.30 pm

**PROGNOSIS**

The prognosis is likely to be good given that there is good family and social support and patient’s commitment to drug compliance.

# CONCLUSION

Mr.E.K was admitted on 01/05/2017 through out patient department escorted by the mother with allegations of talking a lot, hearing voices, being violent and claiming that he was talking with God. A mental status assessment and physical examination was done. A blood slide for malaria parasite was done which turned negative. A diagnosis of bipolar mood disorder manic phase was made and the legal forms filled in duplicate. He remained admitted in Mental Health Unit and daily nursing care including daily bath, individual and group therapy, occupational therapy while in the ward. He was given injection clopixol acuphase,haloperidol tablets and carbamazepine. While in the ward the patient was placed in Firm I and was reviewed every Tuesday and Friday by a psychiatrist. Last review was on 16/05/2017 and he was discharged home on above medications and a return date of one month was given for follow up at the psychiatric outpatient clinic.

# RECOMMENDATIONS

From the history and home visits done some of the recommendations I made are to explain to the patient on the importance of taking drugs as prescribed. It was also noted with concern that the patient did not attend his previous follow up clinic and need to be monitored closely and accompanied during all his follow up visits to the hospital to enable him continue with his work as a mason and avoid hospitalization.

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SUPERVISOR:

DESIGNATION:

SIGNATURE:

DATE SIGNED: