

H31/2494/2013

UNIVERSITY OF NAIROBI

COLLEGE OF HEALTH SCIENCES

SCHOOL OF MEDICINE

EFFIE NAILA KAMADI

H31/2494/2013

LEVEL IV MBCHB

END OF ROTATION REPORT

1. BIPOLAR I MOOD DISORDER

HISTORY

BIODATA

NAME: Judy Waithera Mbao
AGE: 34 Years
GENDER: Female
RESIDENCE: Murang'a
OCCUPATION: Casual Worker
MARITAL STATUS: Separated
RACE: African
EDUCATIONAL LEVEL: Class 8
RELIGION: Christian (Anglican)
VENUE: Ward 5F, Mathari Hospital
DATE OF ADMISSION: 19th October, 2016
MODE OF ADMISSION: Judy was admitted **involuntarily**.

During the interview, Judy was the sole source of information.

Good rapport was established. Regarding her reliability, she was unable to state the presenting complaints in a chronological manner and to recount the specific dates and time frames.

A corroborative history from a relative would be necessary but none was available at the time of the interview.

ALLEGATIONS

Judy presented at the out-patient department on 19th/October/2016 in the company of her pastor and her cousin.

It was alleged that she had been **unable to sleep** for 3 weeks prior to her admission and that she had been **violent** and had displayed **bizarre behavior** 2 days before admission.

HISTORY OF PRESENTING COMPLAINT

Judy Waithera is being managed for Bipolar Mood Disorder.

She had been stable on medication until 3 weeks prior to admission when she developed **initial insomnia** associated with **wandering away from home, undressing in public** and **being violent**. She reported no recent psychosocial stressors that may have resulted in the symptom flare-up.

It is alleged that Judy would stay awake until around 2:00 am in the night. During this period she was predominantly occupied by **worries about lack of food** as she had no stable source of income and survived on provisions from good samaritans.

She would inexplicably leave her house and go to the road where she would wander around, **pick up papers, sing loudly** and later fall asleep by the roadside. This occurred recurrently on a daily basis for three weeks before presentation.

Two days before admission, she displayed bizarre behavior and violence. The bizarre behavior, she reported, was triggered by a visit from a person called Albert whom she claimed is her friend. When Albert came to her house, she started singing loudly and **talking a lot** because she likes him. She claimed

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that her neighbors, out of jealousy, chased Albert away and asked him to avoid interacting with her. This **provoked her to anger** (irritable mood). She started **abusing** them and **throwing stones** at them while **undressing publicly**. She then ran to the roadside where she continued throwing stones at people whom, at this point, she claimed were Luos who had come to snatch Kikuyus' land.

Her cousin and her pastor arrived at the scene, seized her and put her in a vehicle. They then embarked on a 2 day journey from Murang'a to bring Judy to Mathari Hospital.

On further inquiry, she claimed that she left her home because one of her neighbors, who is a devil worshipper, wanted to recruit her into a cult. She also claimed that most of her neighbors envy her and are out to demolish her house so as to rid the neighborhood of her.

She also claimed that she was not concerned about the insecurity that spending nights out in the open posed since, she had been trained by the Al shabaab Military and so **neither the police nor thieves could harm her**. She cited one instance where, in an encounter with the police, she was shot in the head but she survived after the bullet was removed in Kenyatta Hospital. **She claimed that she had a scar on her head** but on examining her, it was non-existent. She added that since that incident, **she and the police in Murang'a town have been very good friends (over-familiarity)**.

She acknowledged that she **heard a voice** that she could not recognize, calling her name repeatedly, 'Judy! Judy!'.

Post-admission, she reported having **illusions** where she would see snakes on the heads of ladies whose hair was braided.

She reported that she was **not taking care of her hygiene** because at the time she felt she needed warm water to do so and it was unavailable.

She **denied feeling demotivated or lacking social interest** during the period of her recent episode of illness and admitted to being **very sociable and active**. She however reported, that there were certain periods where she would have a **depressed mood** and she would cry a lot because she had no food to eat or water to bathe and she stayed alone.

She admitted to **not complying to her medication** since at some point she didn't have enough money to purchase the prescribed drugs. Her relatives do not support her financially and she stays alone.

She denied having any organic medical condition that she knew of, taking alcohol, chewing miraa, smoking bhang or experiencing any recent traumatic experiences.

She reported that her appetite was normal and that her **sex drive was reduced** since she claimed she was circumcised and had a tubal ligation done on her in 2009.

At the time of admission, she was not on any medication but she claimed to have been on **Quetiapine** and **Olanzapine** in the past which controlled her symptoms. She reports no known drug allergies.

On admission she was put on: **intramuscular Fluphenazine (Modecate), 25 mg stat then monthly; Haloperidol 10mg PO BD; Carbamazepine (Tegretol) 400g PO BD and Artane (Trihexyphenidyl) 5g PO TDS.**

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PAST PSYCHIATRIC HISTORY

Judy has had 4 past episodes of mental illness. In all instances, the relapses were due to poor compliance to medication. She was first diagnosed with Bipolar Mood Disorder in 2006.

- Her first episode was in 2002, 1 week after she gave birth to her first child. She reports she did not seek any medical assistance.
- She had a second episode in 2006. She also reports that she did not seek any medical assistance.
- She had a third episode in 2008, four months after she gave birth to her second child. She was brought to Mathari Hospital on 16th/October/2008 with the following allegations for a month:
 - **Being violent and abusive, talkativeness, roaming aimlessly, undressing in public and insomnia.**

She was admitted to ward 2F and put on **Carbamazepine, 400mg BD and Chlorpromazine 200mg BD.**

- She had a fourth episode in 2012 and she was brought to Mathari Hospital on 19th/January/2012 with the following allegations for an unspecified duration:
 - **Violence, shouting and talkativeness.**

She was admitted to ward 2F and put on **Haloperidol 5mg, PO BD and Carbamazepine 400 mg BD.**

Judy reported that she had **attempted suicide in 2016** where she wanted to jump over a bridge into a lake. She said the reason of doing that was because **she felt hopeless** after both her children were taken away from her by her husband and sister respectively. She also had **feelings of worthlessness** since her attempts of securing a hair-dressing job proved futile after several employers turned her down after branding her a 'mad woman'. She said **her attempts were thwarted** by a man called Mburu, her friend, who stopped her from jumping into the lake.

She admitted to **hating her elder step-sister, Ann Wanjira**, so much that she would kill her. This was because Ann, who lives with Judy's son, never allowed Judy to interact with her son. She has however never tried to harm her sister.

PAST MEDICAL HISTORY

Judy has no other chronic illnesses and has never been admitted in a medical or surgical ward.

She is HIV negative.

She has had no blood transfusion and has no known food or drug allergies.

Obstetric history

Judy is a para (2 + 2).

She reported that she procured 2 abortions in 2000. Both were 3 month pregnancies.

Her first delivery was a normal, spontaneous, vaginal delivery in Murang'a District Hospital on September 7th 2002. She labored for 15 hours and an episiotomy had to be done. The baby was a 3.2 Kg female named Everlyne Wanjogu. She didn't cry spontaneously. Everlyne is alive and well and stays with Judy's ex-husband. She goes to school.

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Her second delivery was also a normal, spontaneous vaginal delivery on May 13th 2008 at home. The baby was a male named Victor Kimani. She took the baby to hospital immediately after delivery where he weighed 3.3 kg. Victor is alive and well and stays with Judy's sister, Ann Wanjira. He goes to school.

Gynecologic history

Judy's menarche was at 15 years and her menstrual cycle has been regular.

She denied ever using any contraceptives but claimed that on the realization that **her mental illness episodes were triggered by childbirth, a tubal ligation was performed on her in 2009.**

She reported contracting Syphilis and another unspecified sexually transmitted disease in the year 2002.

FAMILY HISTORY

Her nuclear family is composed of her father, 7 siblings and herself. Her mother is deceased. She is the fifth born.

Judy reported that she is not aware of any mental illness cases in her extended family.

- Her Father (Benard Mbao Mburu) is alive and healthy. He is a retired accountant. While growing up, he was violent towards Judy's mother. He is an alcoholic. **Their relationship is strained since the father does not support her financially or emotionally.**
- Her Mother (Everlyne Mwihaki Mburu) passed on in 1996 due to an unspecified chest condition. **She also developed a mental illness** after Judy's father became violent and financially unsupportive to the family. Judy also claimed that **her mother's mental illness episodes were triggered by childbirth.**
- Her eldest step-sister is Rose Wanjiku. Rose is a 45 year old business woman who is divorced with 2 children. She doesn't abuse any psychotropic substances and has no mental illness. Rose and Judy have a good relationship.
- The second born is Ann Wanjira who is Judy's step sister. Ann is a 41 year old farmer who is married with 2 children. Ann doesn't abuse any psychotropic substances and has no mental illness. **Ann and Judy have a strained relationship** since Ann stays with Everlyne, Judy's first born daughter, and never allows Judy to interact with her daughter.
- The third born is Grace Nyambura who is also Judy's step sister. Grace is a 40 year old shopkeeper who is married with 4 children. She doesn't abuse any psychotropic substances and has no mental illness. Grace and Judy have a good relationship
- The fourth born is Cecilia Wanjiru who is Judy's step sister. Cecilia is 37 years old. She stays in Mombasa and Judy doesn't know what she does for a living. Judy however reported that she and Cecilia have a good relationship as Cecilia often buys Judy clothes and food. Cecilia is married with 2 kids and as far as Judy knows, she doesn't abuse any psychotropic substances and has no mental illness.
- The sixth born is Martin Mburu, Judy's brother. Martin is a 33 year old casual laborer who is not married. Martin takes alcohol, cigarette and bhang but he has no mental illness. Judy and Martin have a good relationship.

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- The seventh born is Kennedy Kang'ethe who is 31 years old. He is a business man who is not married and has no house. Kennedy chews miraa and takes alcohol. **Kennedy has a mental illness** and is currently admitted at Mathare in 6M. Judy claimed that **they have a bad relationship since Kennedy raped her as well as one of his nieces.**
- The last born is Susan Wanjiku who is 29 years old. Judy claimed that Susan is a prostitute who works in a club and is HIV positive and has refused to take medication. Susan takes alcohol and chews miraa but has no mental illness. They however have a good relationship.

PERSONAL HISTORY

Prenatal, Birth and Childhood Development History

Judy was born in 1982 in Murang'a District Hospital. It was a normal, spontaneous vaginal delivery. She claimed that she was a big baby. There were no complications during the pregnancy or delivery. She achieved her milestones on time and that's all she remembers about her birth and development. Judy's primary caregiver was her mother. She breast-fed well. As she grew up, **she was a child that kept to herself and disliked the company of other children as she had a quick temper.** She was of good health all through her childhood. She was **frequently exposed to verbal conflict between her parents** and her father was not financially supportive since he would spend most of his earnings on alcohol.

Educational and Occupational History

Judy started school when she was 7 years old at St. Mary Primary School. She said that **she experienced a lot of difficulties through her schooling life** where she laid specific emphasis on being afflicted by jiggers as her father never bought her shoes. **Her play was of the unoccupied category** where she would rarely engage in play with other children but would stand in one spot. She took up no leadership responsibilities and was rarely punished for any offence. She scored 527 marks out of 700 in her KCPE but claimed she **couldn't go to high school since her results were hid by the primary school.** After class 8, Judy engaged in casual jobs like washing clothes for a fee. She **trained in hairdressing** at an unspecified date in her youth.

MARITAL HISTORY

Judy was first married in 2002 to John Wanyoike when she was 20 years old. They courted for 2 years before discovering that she was pregnant. She then moved in with James. She said she was generally happy in the first months of their marriage since her husband would support her financially in such a way that other members of her family and her neighbors envied her.

She claimed that, during an unspecified period, **John started becoming unfaithful and even infected her with Syphilis.** She claimed that John beat her only twice during the period they were married. **They got one child after which Judy developed her first mental illness episode.** Consequently, **John took the child with him, left Judy and remarried.**

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Judy then got romantically involved with Hussein Maina in 2004 through to 2008 when she got pregnant with her second child. Their relationship was purely sexual but they never lived together. Judy claimed that Hussein would treat her contemptuously after every sexual encounter but would later look for her when he needed sexual favors.

PSYCHOSEXUAL HISTORY

Judy is heterosexual. Coitarche was at 18 years with her first husband, John Wanyoike. **She claimed to have had almost 10 sexual partners ever since.** Her current sexual partner is Peter Njoroge with whom they **use no protection during sexual intercourse.** She claimed satisfaction with both the act and the frequency but also asserted that she can do without sex for up to a year or more. **She attributed her decreased libido to her being circumcised.**

She admitted to having been **raped by Kennedy, her younger brother, in 2015.** She reported having **contracted Syphilis** in the course of her first marriage.

SOCIAL HISTORY

Judy denied taking alcohol, smoking bhang or chewing miraa.

She loves to sing and she said that she is a very active and sociable person.

She goes to the Anglican Church where she likes to dance.

FORENSIC HISTORY

Judy denied ever being arrested or being placed in police custody.

PRESNT LIFE CIRCUMSTANCES AND PREMORBID PERSONALITY

Judy currently stays alone and is not visited by her relatives. She said she has no close friends and to earn a living, she washes clothes for a fee.

Before she developed the mental illness, she claimed that she was a quiet person who liked to keep to herself.

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SYSTEMIC INQUIRY

- Cardiovascular System → **She reported getting occasional palpitations.** She reported no syncope, no dizziness, no dyspnea and no paroxysmal nocturnal dyspnea.
- Gastrointestinal System → She reported no abdominal pain, no diarrhea, no constipation and a good appetite.
- Central Nervous System → She reported no headaches, no dizziness, no weakness, no photophobia and no vomiting.
- Respiratory System → She reported no dyspnea, no chest pain and no cough.
- Genitourinary System → She reported no dysuria, no nocturia, and no urge incontinence.

PHYSICAL EXAM

She has no clubbing, no jaundice, no pallor, no cyanosis, no lymphadenopathy and no edema. **Her eyes however show marked redness.**

- Cardiovascular System → S1, S2 heard. No murmurs heard.
- Gastrointestinal System → There is no tenderness or organomegaly.
- Central Nervous System → Her GCS is 15/15. She has no neurological deficits.
- Respiratory System → She has clear lung fields bilaterally. Vesicular sounds are heard on auscultation.
- Musculoskeletal → No abnormal movements are noted.

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MENTAL STATUS EXAMINATION

APPEARANCE AND BEHAVIOR

Judy appears to be in good physical health, with a normal body habitus. She is **unkempt and has poor personal hygiene**. Her dressing is age-appropriate.

She maintains a normal posture and gait. **She seems agitated** but is cooperative

She maintains eye contact and is cooperative.

CONVERSATION AND SPEECH

Her speech volume is raised and the rate is fast (**Pressured speech**). She occasionally stutters and has **slurred articulation** but her speech content is coherent and relevant. She volunteers information spontaneously

THOUGHT

Judy's thought process is significant for **flight of ideas** where her thoughts and conversations quickly move from one topic to the other. She also displays **circumstantiality** where the point of conversation is reached eventually but with over-inclusion of irrelevant details.

Her thought content is significant for:

- **Somatic delusions** → she claims to have a scar on her head of a gunshot wound that she survived. On examination there was no such scar.
- **Grandiose delusions** → she claims to have received training as a militant by the Al Shabaab in the United States of America that renders her invincible. She also claims that she owns a lorry that she has packed outside the ward and no amount of trying to convince her otherwise makes her change her mind.
- **Paranoid delusions** → she also has multiple claims of her neighbors trying to recruit her into devil worship and to destroy her house.

MOOD AND AFFECT

On day 1 and 3 of the Mental Status Examination, Judy reports that her mood is happy and the affect as observed during the interview is **labile**. Her affect is full and congruent to the content of the conversation.

On day 2 of the Mental Status Examination, Judy reports that **her mood is depressed and the affect as observed is dysthymic**.

ABNORMAL PERCEPTIONS

She expresses disturbances in perception as she admits to **frequent 2nd person auditory hallucinations** calling her name as well as **visual hallucinations** where she sees snakes under her bed. She also reports having **illusions** where long braided hair appears like snakes on people's heads.

DEMENTIA AND COGNITION SCREEN

- **Consciousness:** Judy is fully alert.
- **Orientation:** She is oriented in person as she is able to identify herself. She is oriented in place as she knows that she is in Mathari hospital ward 5F. She is oriented in time as she can approximate the time.
- **Concentration:** Her concentration is good. She is able to recite the months of the year backwards from December to January.
- **Memory:** Her short term memory is good as she is able to register and recall three objects after 5 minutes. Her recent memory is good as she is able to describe the chronology of different events in her recent past during the interview. Her long term memory is good as she is able to recall the school in which she attended primary.
- **Abstract thinking:** She has good abstraction. She is able to give the concrete and abstract meaning of the proverb 'Hurry! Hurry! Has no blessings'. She says that when things are done in a hurry, one is prone to making mistakes.
- **Judgment:** Judy has good judgment. If a friend dropped a wallet containing identification documents on the road, she would pick the wallet and return it to the friend.
- **Intelligence:** Judy's intelligence is normal in relation to her level of education.

INSIGHT

Judy has **full insight**.

She is aware that her experiences are abnormal and are as a result of a pathological process.

She has accepted the need for treatment to improve her symptoms and she claims she tries to be compliant with her current medication but for financial constraints that make it difficult.

She is able to recognize the recurrence of her symptoms and seek help.

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RISK ASSESSMENT

Judy admits to having **suicidal ideations** once in the early months of 2016. She had planned to jump over a bridge into a lake. She says that her friend Mburu stopped her when she was just about to jump. She reports no such thoughts ever since and is hopeful about the future.

She denies any current patterns of self-harm.

She reports having had **thoughts of harming her sister**, Ann Wanjira, who stays with Judy's daughter and denies Judy access to her daughter.

FORMULATION

This is a case of Judy Waithera, a 34 year old female of African descent from Murang'a. She is separated from her husband. She is a class 8 drop out who currently does casual work. She was involuntarily admitted to Mathari Hospital, ward 5F a week ago. She presented at the outpatient clinic with allegations of inability to sleep and violence for 3 weeks and bizarre behavior for 1 day.

Judy is being managed for Bipolar Mood Disorder first diagnosed in 2006. The current, is a fifth episode. Her presenting complaints are significant for initial insomnia accompanied by worries about lack of food as well as, disorganized behavior, characterized by wandering away from her house, picking up papers and singing aloud. This went on for three weeks.

Two days prior to admission, she became very talkative and irritable. This progressed to violence towards neighbors and other members of the public, where she would throw stones and hurl abusive insults at them. She also displayed bizarre behavior characterized by stripping naked.

On further inquiry, she claimed that she wandered away from her house because her neighbors envied her and wanted to recruit her into cultic devil worship (paranoid delusion). She also claimed that she was trained by the *Al-shabaab* and that she was invincible (grandiose delusion). She claimed to have a healed gunshot wound on her head from her encounters with the police, this was non-existent on examination (somatic delusion). She claimed to see snakes under the bed and on people's heads (visual hallucination). She claimed to frequently hear a voice she couldn't recognize calling her name (2nd person auditory hallucination). She reported poor hygiene during the current period of illness but denied feelings of low energy and lack of social interest.

There was no prominent life event prior to the symptom flare-up. She admitted to lack of compliance to her medication due to financial constraints.

In the past, Judy reported having been admitted to Mathari hospital twice in a span of 5 years (2008 – 2012). The first admission was after she relapsed due to giving birth to her second child in 2008. She admitted to having attempted suicide once, early in 2015, by jumping into a lake but she was stopped by her friend. She added that she had experienced a few of such moments of low energy and demotivation.

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Judy has a strong family history of mental illness since her late mother as well as her brother is mentally ill. Her brother is currently admitted in Mathari Hospital ward 6M. As she grew up, Judy was frequently exposed to verbal conflict and domestic violence between her parents and she subsequently developed a very quick temper through her primary school. She thus disliked the company of her peers and preferred to stay alone. She had to drop out at class 8 due to financial constraints.

Judy's first husband left her and remarried when she developed her very first episode after giving birth to her first child in 2002. He took their child with him. Judy has since been in over 10 sexual relationships and she claimed that she was raped by her mentally ill brother at some point.

Judy claimed to have never abused any psychotropic substances. Her relatives do not support her and she has no close friends. She has no stable source of income and she stays alone.

On Mental Status Examination, Judy appeared unkempt with poor personal hygiene; she displayed psychomotor agitation but was cooperative. Her speech and conversation was significant for pressured speech and mildly slurred articulation. Her thought process was significant for flight of ideas and circumstantiality. Her thought content was significant for somatic, grandiose and paranoid delusions. Her mood was happy and affect was labile on day 1 and day 3 of the examination. She had a low mood and dysthymic affect on day 2 of the examination. In all instances her affect was full and congruent to the content of the conversation. She acknowledged experiencing 2nd person auditory and visual hallucinations.

She has full insight and is currently compliant on her medication [IM Fluphenazine (Modecate), PO Haloperidol, PO Carbamazepine (Tegretol) and PO Trihexyphenidyl (Artane)]. She shows good treatment response and has no comorbid physical or psychiatric factors.

However, her low level of education, lack of employment, psychotic features, early illness onset and poor social support system, confer on her a poor prognosis.

MULTIAXIAL DIAGNOSIS

AXIS I: BIPOLAR MOOD DISORDER TYPE 1, PRESENTING IN A MANIC PHASE, WITH PSYCHOTIC FEATURES (DSM IV CODE 296.4x)

Judy meets the DSM-IV criteria for Bipolar Disorder Type I:

- a) More than one manic episode
- b) No major depressive episode (not required for diagnosis)
- c) Manic episode is not due to a medical condition, drugs of abuse, toxins or treatment for depression.
- d) Symptoms are not caused by a psychotic disorder.

Judy also meets the DSM-IV criteria for a manic episode:

- a) At least one week of abnormally and persistently elevated, expansive or irritable mood.
- b) During the mood disturbance the following persisted:
 - Inflated self-esteem and grandiosity
 - Decreased need for sleep
 - Talkativeness

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- Flight of ideas
- c) Does not meet the criteria for a mixed episode
- d) Symptoms have caused marked impairment in social and occupational functioning and have required hospitalization to prevent harm to self or to others. Psychotic features (2nd Person Auditory and Visual Hallucinations are present.
- e) The symptoms have not been caused by a medical condition, medication or drugs.

Differential: Schizoaffective disorder.

AXIS II: NO PERVASIVE DEVELOPMENTAL DISORDER OR PERSONALITY DISORDER.

AXIS III: NO GENERAL MEDICAL CONDITION.

AXIS IV: ENVIRONMENTAL FACTORS AND PSYCHOSOCIAL STRESSORS INCLUDE:

- Poor level of education and lack of employment.
- Poor drug compliance due to financial constraints
- She stays alone with no support from her relatives.
- She separated with her husband who remarried.
- She lacks close friends.

AXIS V: GLOBAL ASSESSMENT FUNCTIONING SCORE OF 30.

Her behavior is considerably influenced by delusions and hallucinations and serious impairment in judgment and an inability to function in some areas.

MANAGEMENT

INVESTIGATIONS

1. Biological

- **Blood studies**
 - **Complete Blood Count** with differential is used to rule out anemia which may be precipitated by bone marrow suppressing medication.
 - **Erythrocyte Sedimentation Rate** is determined to look for underlying, inflammatory disease processes.
 - **Fasting Blood Glucose** is performed to rule out diabetes since some atypical antipsychotics have been associated with weight gain and problems with blood glucose regulation in patients with diabetes.

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- **Serum electrolyte concentrations** are measured to help diagnose electrolyte disturbances especially with sodium. This is especially important in candidates for lithium therapy since hypo-natremia can lead to lithium toxicity. Serum calcium levels is assessed since abnormal calcium levels are associated with mental changes.
- **Serum Protein Levels** to assess malnutrition states that may accompany depression.
- **Thyroid hormone panel** is performed to rule out hyperthyroidism in manic patients. Treatment with lithium can also precipitate hypothyroidism which may cause rapid mood cycling especially in women.
- **Creatinine and Blood Urea Nitrogen** to assess kidney function
- **Liver and Lipid panel** is done since antipsychotics have been associated with changes in patients, lipid profiles and liver function.
- **Infection screen:** HIV & Syphilis serology (VDRL) to rule out Neuro-syphilitic etiology of the mental illness.
- **ANF** to rule out Systemic Lupus Erythematosus
- **Urinary studies:**
 - Urine copper to rule out Wilson's disease
 - Urine pregnancy check.
- **Substance and alcohol screening**
- **Imaging**
 - Computed Tomography or Magnetic Resonance Imaging Scan to rule out a medical cause for the mental disorder
 - Electroencephalogram → in manic episodes of people with bipolar mental disorder, one can see increased activity of beta-2 and beta-3 bands in the prefrontal to parietal regions and the cingulate.

2. Social investigations

- Social worker's intervention to examine the patient's microenvironment.

TREATMENT

1. Hospitalization

2. Pharmacotherapies:

- **Carbamazepine** (Tegretol) 400mg PO BD for mood stabilization.
- **Haloperidol** 10mg PO BD to control psychotic symptoms.
- **Chlorpromazine** (Largactil) to control agitation and insomnia.
- **Fluphenazine** (Modecate) 25 mg IM stat then monthly.
- **Trihexyphenidyl** (Artane) 5g PO TDS for drug-induced extrapyramidal symptoms.
- **Electroconvulsive therapy** is third line treatment for severe manic episodes that are unresponsive to medication.

3. Psychological therapies

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- **Cognitive Behavioral Therapy** aimed at increasing awareness of socially acceptable behavior and dealing with the consequences of the manic episodes. Therapy should attempt to help the patient resolve psychotic manifestations.
- Patient **psycho-education**.

4. Social therapy

- Family psycho-education to help increase the family's understanding and tolerance.

PROGNOSIS

- Poor prognostic factors:
 - Low level of education and lack of employment.
 - Psychotic features (Visual and auditory hallucinations as well as grandiose and paranoid delusions)
 - Poor drug compliance due to financial constraints
 - She stays alone with no support from her relatives and no close friends.
 - She is separated from her husband who re-married.
 - Early age of onset (20 years)
- Good prognostic factors:
 - Female gender
 - None co-morbid physical factors
 - Good treatment response
- Therefore, she has a poor prognosis.

2. SCHIZOPHRENIA

HISTORY

BIODATA

NAME: Ann Nyagothie
AGE: 38 years
GENDER: Female
RESIDENCE: Githurai
OCCUPATION: Househelp
MARITAL STATUS: Single
RACE: African
EDUCATION LEVEL: Class 8
RELIGION: Christian
VENUE: Ward 5F, Mathari Hospital
DATE OF ADMISSION: 29th September 2016
MODE OF ADMISSION: Ann was admitted involuntarily. This was an index admission.

During the interview, Ann was the sole source of information.

Good rapport was established. Regarding her reliability, Ann was not a very reliable source because she could not clarify specific details about her illness progression.

A corroborative history from a relative or close acquaintance would be necessary but none was available at the time of the interview.

ALLEGATIONS

Ann presented at the out-patient department on 29th/September/2016 in the company of her pastor and friend with whom she lives. The following allegations were made:

- Roaming aimlessly and talkativeness for 1 month
- Undressing in public for 1 day

HISTORY OF PRESENTING COMPLAINT

Ann Nyagothie was relatively well until 1 month ago when it is alleged, that she inexplicably **fled from her work place** at High-rise to Githurai, at her friend's place. She claimed that the reason she did that was because **there were certain people, led by a senior prophet, who wanted to take away her life**. She said that this was due to the fact that they were jealous of her because God had appointed her a chief prophetess and had commissioned her to preach repentance and to convert nations back to Christianity. She claimed that she had become very popular after holding a major crusade that was aired live on TV and on radio and this was the sole reason behind the senior prophet's attempts on Ann's life.

At Githurai, 1 week before admission, she reported that she started **roaming aimlessly** around the neighborhood and **talking a lot**. She said that she would preach to the people around her and urge them to turn away from their sinful ways of living.

A night before presenting to Mathari, it is alleged that she **undressed in public** and this prompted her friend, accompanied by her pastor, to bring her to Mathari hospital. Ann categorically **denied this allegations** and said that she could not have undressed in public since she is never comfortable with people seeing her naked. Ann reported that there were no recent psychosocial stressors that may have resulted in the symptom flare-up.

On further inquiry, Ann **denied any violent or aggressive behavior**. She **denied ever feeling demotivated or lacking social interest** during the period of her recent episode of illness.

She pointed out that she was a **known hypertensive on medication to which she was not compliant**. She **denied abusing any psychotropic substances**.

She claimed that she could **hear voices of her fellow prophetesses discussing and praying for her**. She claimed to even **see those prophetesses holding hands and praying for her to leave Mathari Hospital**. She also added that she could **hear the voice of the senior prophet telling the rest that Ann was mad and instructing them to go and kill her**.

She reported no change in her bowel habits but **reduced appetite over the past three weeks**. She claimed to have **difficulties sleeping as she would stay awake the whole night**. During this time she said she would pray for the world. She said **she preferred to not take a shower frequently** as she was very busy praying and preaching.

At the time of admission, Ann was not any medication but she was put on **Haloperidol 10mg PO BD and Trihexyphenidyl (Artane) 5g PO TDS**.

PAST PSYCHIATRIC HISTORY

This is her **index admission**. She denied any outpatient visits due to a mental illness.

Ann also **denied any suicidal or homicidal ideations as well as self-harming patterns**.

PAST MEDICAL HISTORY

Ann is a **known hypertensive for 3 years** and is not fully compliant to her medication. She was unable to recall what medication she was on.

She has only been **admitted once** when she was delivering her first born child through an elective caesarean section.

She has never had a blood transfusion and denies any known drug or food allergies.

Obstetric history

Ann is a **para (3 + 0)**.

Her first delivery was an elective caesarean section in 2006. The baby was a female named Nazaria Nyagothie. Ann cannot remember the other details of Nazaria's birth.

Her second delivery was a normal, spontaneous vaginal delivery in 2008. The baby was a male named Murugi Nyagothie. Ann cannot remember the other details of Murugi's birth.

Her last delivery was also a normal, spontaneous vaginal delivery in 2009. The baby was a female named Njeri Nyagothie. Ann cannot remember the other details of Njeri's birth.

All her children are alive and well and they live with her friend in Githurai. They are all going to school.

Gynecologic history

Menarche was at 13 years. Her menstrual cycle has been regular. She denied ever using any contraceptives. She has never contracted any sexually transmitted diseases.

FAMILY HISTORY

Ann is the third born in a family of four children.

Ann's father left her mother and remarried when Ann was a young child. Ann doesn't know anything about her father's whereabouts.

When Ann was 5 years old, **her mother passed on** due to causes unknown to Ann. **Two of her siblings, Lucy Waweru and Mary Wambui are both deceased** due to causes unknown to Ann.

Her elder sister, Hannah Waithera, is the only surviving sibling and she is a housewife. Ann and Hannah have a good relationship. Ann doesn't know any more details about Hannah.

Ann reported that **she is not aware of any mental illness cases or substance abuse in both her nuclear and extended family**.

PERSONAL HISTORY

Prenatal, Birth and Childhood Development History

Ann could not recall the details about her birth or about her developmental milestones.

Ann's mother was her primary care-giver for her first 5 years of life after which **she was raised by her aunts and uncles**. Ann was raised in Nyeri but her family later moved to Embu. **As she grew up, Ann kept to herself and was a very quiet child**. Ann was of good health all through her childhood.

Educational and Occupational History

Ann could not remember at what age she started school. She went through her primary schooling at Kerigi School in Embu where **she dropped out at class 8 due to poor performance and financial constraints**. She scored 239 marks out of 700 in her KCPE.

Her play was of the onlooker category where she would watch other children as they played. She claimed that she did not take up any leadership responsibilities and was rarely punished for any offences.

Ever since Ann dropped out of class 8, she has been working as a house help in High-rise estate. She has only worked for one employer since 2006. She enjoys her work very much and has a good relationship with her employer.

MARITAL HISTORY

Ann is **unmarried**. She has however had sexual relations with 2 men whom she met as she was working as a house-help. She refused to disclose the identity of these men and claimed that she didn't know their whereabouts.

She has had 2 children with the first man and a last child with the other man.

PSYCHOSEXUAL HISTORY

Ann is heterosexual. She claimed that coitarche was at 28 years old. She claimed she has had only two sexual partners. She is currently in no sexual relationship. She denied having been sexually abused or having contracted a sexually transmitted illness. She has not been circumcised.

SOCIAL HISTORY

Ann is a **devoted Christian** who fellowships at Jesus Winner's Ministry where she is a member of the praise and worship team.

She denied any history of psychotropic substance abuse.

She has good relations with her neighbors and friends in the church whom she refers to as prophetesses. She has no close friends.

She loves preaching and singing.

FORENSIC HISTORY

Ann denied ever being arrested or being placed in police custody.

PRESENT LIFE CIRCUMSTANCES AND PREMORBID PERSONALITY

Ann stays with her friend at Githurai. She reported that she has financial difficulties that have rendered her unable to pay rent for the month that she has been admitted in Mathari Hospital. She plans to resume her job as a house-help, once she is discharged, so she can raise money to support herself and her children.

Before she developed the mental illness, Ann claimed that she was a quiet lady who liked to keep to herself.

SYSTEMIC INQUIRY

- **Cardiovascular System** → She reported getting frequent palpitations. She reported no syncope, no dizziness, no dyspnea and no paroxysmal nocturnal dyspnea.
- **Gastrointestinal System** → She reported no abdominal pain, no diarrhea, no constipation and a good appetite.
- **Central Nervous System** → She reported experiencing headaches accompanied by dizziness. She however reported no weakness, no photophobia and no vomiting.
- **Respiratory System** → She reported no dyspnea, no chest pain and no cough.
- **Genitourinary System** → She reported no dysuria, no nocturia, and no urge incontinence.

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PHYSICAL EXAM

She has no clubbing, no jaundice, no pallor, no cyanosis, no lymphadenopathy and no edema.

- **Cardiovascular System** → S1, S2 heard. No murmurs heard. Her BP is 145/90.
- **Gastrointestinal System** → There is no tenderness or organomegaly.
- **Central Nervous System** → Her GCS is 15/15. She has no neurological deficits.
- **Respiratory System** → She has clear lung fields bilaterally. Vesicular sounds are heard on auscultation.
- **Musculoskeletal** → She has a slight tremor on her left hand.

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MENTAL STATUS EXAMINATION

APPEARANCE AND BEHAVIOR

Ann appears to be in good physical health, with a normal body habitus. **She is dirty, unkempt and smelly.** Her dressing is age-appropriate.

She **slightly leans towards the left** when seated and **her left hand has a slight tremor.** She displays psychomotor retardation.

She maintains eye contact. She is **initially uncooperative** with claims that God is asking her to stop answering any more questions but she becomes receptive later on. Rapport is established but with difficulty.

CONVERSATION AND SPEECH

Her **speech volume is low and the rate is slow.** She occasionally stutters but her articulation is good and the speech content is coherent and relevant. She gives **passive, one word answers.**

Her speech is significant for **perseveration** where she persistently repeats the claims that she is a prophetess and she can foretell people's futures by simply looking at them.

THOUGHT

Ann's thought process is significant for **poverty of thought** where she expresses few ideas as well as **thought blocking** where she abruptly ceases communicating before she completes passing across an idea.

Ann's thought content is significant for:

- **Religious delusions** → God appointed her to be a chief prophet.
- **Grandiose delusions** → she claims that she is the world's chief prophetess and is very popular since she frequents presides over major crusades that are aired live on TV and radio. She claims she can foretell the future.
- **Paranoid delusions** → she also claims that she can foretell the future. She claims that due to her greatness as a prophetess, other less significant prophets and prophetesses want to kill her.

MOOD AND AFFECT

Ann reports that **she is happy.** On observation during the interview, **her affect is elated, full and congruent** to the content of the conversation.

ABNORMAL PERCEPTIONS

Ann expresses disturbances in perception as she admits to **frequent 3rd person auditory hallucinations** where she hears other prophets and prophetesses discussing her and planning to kill her. She also acknowledges experiencing **visual hallucinations** where she sees these prophets actually holding hands praying for her so she can leave Mathari Hospital.

DEMENTIA AND COGNITION SCREEN

- **Consciousness:** Ann is fully alert.
- **Orientation:** She is oriented in person as she is able to identify herself correctly. She is oriented in place as she knows that she is in Mathari hospital, ward 5F. She is oriented in time as she can correctly approximate the time.
- **Concentration:** Her concentration is good. She is able to recite all the days of the week backwards from Sunday to Monday.
- **Memory:** Her short term memory is good as she can recall three objects after five minutes. Her recent memory is good as she is able to describe the chronology of different events in her recent past during the interview. Her long term memory is good as she is able to recall her primary school.
- **Abstract thinking:** She has good abstraction as she can correctly interpret the concrete and abstract meaning of a Swahili proverb, 'Asiyesikia la mkuu huvunjika guu'. She says that disobeying authority has dire consequences.
- **Judgment:** Her judgment is good since she says that if she comes across a fire with a child inside, she would try and save the child.
- **Intelligence:** Ann's intelligence is normal in relation to her level of education.

INSIGHT

Ann has **no insight**.

She is not aware that her experiences are abnormal and are as a result of a pathological process.

She has not accepted the need for treatment to improve her symptoms.

RISK ASSESSMENT

Ann denies having any suicidal or homicidal ideations. She denies any current patterns of self-harm.

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FORMULATION

This is a case of Ann Nyagothie, a 38 year old female of African descent from Githurai. She is unmarried. She is a class 8 drop out who is currently a house-help at High-rise. She was involuntarily admitted to Mathari Hospital, ward 5F 1 month ago. She presented at the outpatient clinic with allegations of roaming aimlessly and talkativeness for 1 month and undressing publicly for 1 day.

This is Ann's index admission. Her presenting complaints are significant for fleeing from her place of work at High-rise to Githurai, a month prior to admission, with claims that since she was appointed by God as a chief prophetess, other prophets and prophetesses wanted to take away her life (paranoid, religious delusion). She claimed that she was a very popular prophetess who could foretell the future and that she had held so many powerful crusades that were aired live on TV and on radio (grandiose delusions). At Githurai where she stayed with her friend, she developed talkativeness and would roam aimlessly claiming to preach to people. She also reported that she would stay awake the whole night praying for the world. One day prior to admission, it was alleged that Ann undressed in public. She, however, denied this.

On further inquiry, Ann claimed that she could hear voices of her fellow prophetesses discussing and praying for her (3rd person auditory hallucination) and added that she could see them holding hands and praying for her to leave Mathari Hospital soon (visual hallucination). Ann reported reduced appetite and that she preferred not taking a shower during her period of illness. There was no prominent life event prior to the symptom flare up.

Ann is a known hypertensive for 3 years and is currently on medication to which she is not compliant.

Her Father left their family and remarried when Ann was an infant. Ann's mother passed on when she was 5 years old. Two of her 3 siblings are also deceased for causes unknown to her. There is no history of mental illness or substance abuse in her nuclear or extended family. After her mother's death Ann was raised by her aunts and uncles and she was a very quiet child that kept to herself. Through her primary schooling, her play was of the onlooker category and she was always aloof. Ann dropped out of school in class 8 due to financial constraints and poor performance.

Ann is unmarried but she has 3 children with 2 different men whose whereabouts she doesn't know. She is a devoted Christian who goes to Jesus Winner's Ministry and has good relations with her neighbors. She has no close friends. She complained of financial constraints.

On Mental Status Examination, Ann appeared dirty and unkempt. She slightly leaned towards the left when seated and her left hand had a slight tremor. She had psychomotor retardation, was initially uncooperative but rapport was established eventually. Her speech and conversation was significant for low volume and slow rate, preservation as well as passive, one word answers. Her thought process was significant for poverty and thought blocking. Her thought content was significant for grandiose, religious and paranoid delusions. Her mood was happy and her affect was elated, full and congruent to the content of the conversation. She acknowledged experiencing frequent 3rd person auditory hallucinations as well as visual hallucinations.

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She has no insight and is currently on medication [PO Haloperidol and PO Trihexyphenidyl (Artane)] She hasn't shown good treatment response yet. The fact that she has a late and acute onset of symptoms, good premorbid social and occupational history, preponderance of positive symptoms, preservation of adequate affective expression and abstinence from psychotropic substance abuse confers on her a good prognosis.

MULTI-AXIAL DIAGNOSIS

AXIS I: SCHIZOPHRENIA PARANOID TYPE (DSM IV CODE 295.30)

Ann meets the DSM-IV diagnostic criteria for Schizophrenia:

- a) Grandiose and paranoid delusions as well as visual and auditory hallucinations for 1 month.
- b) Decline in occupational functioning since the onset of illness.
- c) One month of active symptoms.
- d) Schizoaffective disorder and mood disorder with psychotic features have been excluded.
- e) No history of autistic or pervasive developmental disorder.

Ann also meets the DSM-IV diagnostic criteria for Paranoid Type Schizophrenia:

- a) She is preoccupied with delusions of grandeur and paranoia as well as frequent auditory hallucinations.
- b) She does not display disorganized speech, catatonic behavior or flat affect.

Differentials:

- Brief psychotic disorder
- Schizoaffective disorder
- Mood disorder with psychotic symptoms
- Delusional disorder

AXIS II: NO PERVASIVE DEVELOPMENTAL DISORDER OR PERSONALITY DISORDER

AXIS III: KNOWN HYPERTENSIVE FOR 3 YEARS

AXIS IV: ENVIRONMENTAL FACTORS AND PSYCHOSOCIAL STRESSORS INCLUDE:

- Financial constraints and low level of education.
- Single motherhood.
- Poor social support systems

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AXIS V: GLOBAL ASSESSMENT FUNCTIONING SCORE OF 35.

Ann has some impairment in reality testing that has affected her occupational and interpersonal functioning.

MANAGEMENT

INVESTIGATIONS

1. Biological

- **Blood studies**
 - **Complete Blood Count** with differential is used to rule out anemia which may be precipitated by bone marrow suppressing medication.
 - **Liver, thyroid and renal function tests.**
 - **Electrolyte, glucose, vitamin B-12, folate and calcium levels,**
- **Pregnancy testing**
- **Urine tests for drugs of abuse (alcohol, cannabis)**
- **Urine for culture and sensitivity (to look for urinary tract infection)**
- **Brain imaging**
 - Computed Tomography or Magnetic Resonance Imaging Scan to rule out subdural hematomas, vasculitis, cerebral abscesses and tumors.
 - Electroencephalogram → reduced mismatch negativity (MMN) and P3a
- **Urine and serum copper and ceruloplasmin (to rule out Wilson's disease)**
- **Dexamethasone suppression test for hypercortisolism**
- **Rapid Plasma regain test to rule out syphilis.**
- **HIV antibodies.**
- **Antinuclear antibodies to rule out Systemic Lupus Erythematosus.**

2. Social investigations

- Social worker's intervention to examine the patient's microenvironment.

TREATMENT

1. Hospitalization

2. Pharmacotherapies

- **Haloperidol** 10mg PO BD to control psychotic symptoms
- **Fluphenazine** (Modecate) 25 mg IM stat then monthly
- **Trihexyphenidyl** (Artane) 5g PO TDS to control dystonic movements.

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3. Psychosocial therapies

- Insight-oriented psychotherapy to manage delusions
- Cognitive behavioral therapy.
- Group psychotherapy will enable the patient to achieve relief of symptoms and resolve intra-psychic and interpersonal problems as a result of interactions with other patients and the therapist.

4. Social therapy

- Psycho-education of family members and caretakers to help increase the family's understanding and tolerance and

PROGNOSIS

- Good prognostic factors
 - Female
 - Late and acute onset of symptoms
 - Good premorbid social and occupational history
 - Preponderant positive symptoms (hallucinations and delusions)
 - Preservation of adequate affective expression
 - Early adequate treatment.
 - No substance abuse
 - Paranoid sub-type
- Poor prognostic factors
 - No precipitating factors
 - Single motherhood
 - Low level of education
- Therefore, her prognosis is good.

3. INTELLECTUAL DISABILITY

HISTORY

BIODATA

NAME: Jane Wambui Kamau
AGE: 18 Years
GENDER: Female
RESIDENCE: Githunguri, Ngewa
MARITAL STATUS: Single
RACE: African
EDUCATIONAL LEVEL: Class 1 pupil at Ngewa Special School
RELIGION: Christian
VENUE: Kenyatta National Hospital Youth Clinic
DATE: 10th October, 2016

Jane is unable to communicate. The informant was Keziah Njeri, who is her neighbor and primary care giver.

Rapport was established with Keziah and the information given is reliable since she has been very close to Jane's family since Jane was 4 years old.

A corroborative history from Jane's mother would be necessary but **she went to Saudi Arabia to work as a house-help in 2008 after Jane's father's demise.**

PRESENTING COMPLAINT

Jane was brought to the Youth Clinic accompanied by Keziah Njeri to obtain a psychiatric assessment required by the Senior Principal Magistrate's Court at Githunguri, after she was **defiled by a young man on the 7th of September 2016.**

HISTORY OF PRESENTING COMPLAINT

Keziah reported that on the morning of 7th September, 2016, Jane left the house and went to visit her mother's brother, Joseph, who stayed at a walking distance within Ngewa.

At Joseph's place, Jane spent the whole day playing with other children. At around 4:00 pm, as narrated by the children she was playing with, Keziah reported that Jane was called by Mbiriti, a man who stayed in the neighborhood. Jane voluntarily went into his house alone.

When Jane's aunt noticed her absence, she inquired from the children about her whereabouts. Jane's aunt raised alarm and started calling out Jane's name around. Other neighbors gathered around Mbiriti's house when they heard Jane responding from there. This prompted him to leave the house accompanied by Jane. On questioning, Mbiriti claimed that Jane was an adult who could make sound decisions on her own. The police were informed and they arrived at the scene. Mbiriti was arrested and placed in custody and Jane was taken to Kiambu District Hospital.

At the hospital, **Jane was put on a post-exposure prophylaxis regimen for 2 weeks. She was also found to be 4 months pregnant.**

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On further inquiry, Keziah reported that Jane had a **longstanding history of defilement for the past 1 year** since she frequently noted a slippery substance around Jane's genitals when Keziah helped her to take a shower. She concluded that it was semen.

There was **no further clinical follow-up for defilement**.

Keziah reported **no overt changes in Jane's mood** ever since. Jane was alleged to have no chronic medical condition and no history of abuse of psychotropic substances.

Keziah however noted that after the incident, Jane **avoids men as well as leaving the house on her own**. She added that Jane has since **regressed to a lower developmental stage where she wets herself if startled**. She added that **Jane's concentration has decreased** since when asked to perform a task, she takes abnormally long to do it. She particular cited an instance where, Jane took over an hour to get a sweater from another room within the house.

Keziah denied any behavioral changes or mannerisms that may have suggested that Jane was experiencing hallucinations or delusions.

Keziah had noted no patterns of self-harm or animosity towards other people in Jane.

Keziah reported that Jane had no changes in appetite, bowel movements or sleep patterns.

Jane was on no medication at the time of the interview.

PAST PSYCHIATRIC HISTORY

Jane has had no previous comorbid mental illnesses. She has however been intellectually disabled since birth.

PAST MEDICAL HISTORY

Jane has no other chronic illnesses. She has no known food or drug allergies and has never been admitted before. She has never had a blood transfusion.

Obstetric history

Jane is a **primi-gravida**.

She is currently 4 months pregnant. She has **not started attending antenatal clinics** and is not on any nutritional supplements. So far, she has no medical complaints pertaining her pregnancy.

Gynecologic history

Jane's menarche was at 15 years. Her menstrual cycle has been regular. She has never used any contraceptives. She has never contracted any sexually transmitted diseases. **She has a long-standing, 1 year history of defilement**.

FAMILY HISTORY

Jane is the last born in a family that consists of her Mother and 2 siblings. **Her father is deceased.**

- Jane's father (Peter Kirika) passed on in 2008 after he was involved in an accident as he was cutting down trees. He was a carpenter who **had a very good relation with Jane**. He was a peaceable man who rarely engaged in verbal conflict with Jane's mother. He did not abuse any psychotropic substances and had no mental illness.
- Jane's mother (Faith Wanjiru) is 45 years old. **She left for Saudi Arabia to look for a job as a house-help after she and her children were chased away from her matrimonial home**. She doesn't abuse any psychotropic substances. She has no mental illness. Keziah reports that Jane and her mother **have a good relation** despite their temporary separation.
- The first born (Peter Kinuthia) is 28 years old. He is a tout in public service vehicles plying the Githurai route. He abuses alcohol, cigarette and miraa. He, however, has no mental illness. **His relationship with Jane is strained as he rarely interacts with her**.
- The second born (Joseph Kamau) is 25 years old. He is a business man. He doesn't abuse any psychotropic substances. He has no mental illness. He has a good relationship with Jane.

PERSONAL HISTORY

Prenatal, Birth and Childhood Development History

Jane was born on the 24th/April/1998 in Kiambu District Hospital.

It was a normal, spontaneous vaginal delivery with no complications during the pregnancy or delivery. She **achieved her milestones very late**. Keziah reported that Jane **started talking at 16 years of age and started toilet-training at 17 years**.

Jane's primary caregiver, as she was growing up, was her mother. She breast-fed well. She was a child that kept to herself and **liked the company of children much younger than herself**. She was of good health all through her childhood.

Educational History

Jane started school when she was 7 years old at Mt. Moriah Nursery School. **Jane's performance was very poor** and after one term it was recommended that she be **moved to a special school**. She was then transferred to Komothai Special School where she schooled for 1 term. She was later transferred to Ngewa Special School which was closer to home and has been in Ngewa ever since.

She is in class 1 and her performance is still very poor. Her play is of the parallel category where she plays separately from other children but in a manner that mimics their play. **She still prefers playing with children who are much younger than her (2 – 3 years)**. Jane has assumed no leadership roles and she does not involve herself in any extra-curricular activities. She has not been punished for any offences.

PSYCHOSEXUAL HISTORY

Jane's coitarche, as Keziah reported, was in the early months of 2015. She has **a longstanding, 1 year history of defilement by unknown people**. She is not circumcised.

SOCIAL HISTORY

Jane does not abuse any psychotropic substances.

She loves playing with children younger than her age.

She goes to Ngewa Pentecostal Church. She has no close friends.

FORENSIC HISTORY

Keziah reported that Jane had never been arrested or put in police custody.

PRESENT LIFE CIRCUMSTANCES

Jane currently stays with Keziah who takes care of her personal hygiene as well as her daily needs. Jane's mother occasionally sends money to Keziah for Jane's upkeep. Keziah reported that Jane has never been physically abused.

SYSTEMIC INQUIRY

It was impossible to assess Jane's body systems since she is unable to communicate.

PHYSICAL EXAM

She has no clubbing, no jaundice, no pallor, no cyanosis, no lymphadenopathy and no edema.

- **Cardiovascular System** → S1, S2 heard. No murmurs heard, BP of 115/73 mmHg.
- **Gastrointestinal System** → There is no tenderness or organomegaly. Her abdomen is mildly distended.
- **Central Nervous System** → Her GCS 15/15. She has no neurological deficits.
- **Respiratory System** → She has clear lung fields bilaterally. Vesicular sounds are heard on auscultation.
- **Musculoskeletal** → No abnormal movements are noted.
- **Genitourinary system** → It is reported that Jane has nocturnal urinary frequency and occasional enuresis. No dysuria and no per-vaginal bleeding is reported.

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MENTAL STATUS EXAMINATION

APPEARANCE AND BEHAVIOR:

Jane appears to be in good general health condition, with a normal body habitus. She is well-kempt with no postural and gait abnormalities. Her dressing is age-appropriate. **She smiles spontaneously and occasionally for no apparent reason.** She displays psychomotor retardation. She is relaxed.

CONVERSATION AND SPEECH

Jane's speech is **retarded with a low tone.** Her articulation is **moderately slurred** and she gives **passive, one-word answers to a few questions.**

THOUGHT

Jane's thought process is significant for **poverty of thought** as too few ideas were expressed. She is only able to say her name, school and residence.

From observing her mannerisms, no abnormalities of thought content can be picked up.

MOOD AND AFFECT

Jane appears **euthymic** during the interview. Her **affect is restricted and incongruent** to the content of the conversation

ABNORMAL PERCEPTIONS

From observing her mannerisms, there are no signs of abnormal perceptual experiences.

DEMENTIA AND COGNITION SCREEN

- **Consciousness:** Jane is fully alert
- **Orientation:** Jane is oriented in person as she can correctly identify herself. **She is not oriented in time or place as she cannot tell what time it is or where she is.**
- **Concentration:** Her **concentration is poor** as she is easily distracted during the interview.
- **Memory:** Her **memory is poor** as she is unable to perform 2 consecutive tasks given to her
- **Abstract thinking:** It is impossible to assess her abstract thinking because of her lack of response to the questions asked.
- **Judgment:** It is impossible to assess her judgment because of her lack of response to the questions asked.
- **Intelligence:** Jane's **intelligence is very low.**

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INSIGHT

Jane has **no insight**.

She is not aware that she is pregnant and Keziah reports that when asked why her abdomen is gradually distending, Jane attributes it to having had a very satisfying meal of rice.

RISK ASSESSMENT

Jane does not display any patterns of self-harm. She has shown no animosity towards other people.

FORMULATION

This is a case of Jane Wambui Kamau, an 18 year old female of African descent from Githunguri. She is single and in class 1 at Ngewa Special School. She is intellectually disabled since birth and is unable to communicate effectively. The informant is Keziah Njeri, her primary caregiver, who brought her to the Kenyatta Hospital Youth Clinic for a psychiatric assessment required by the Senior Principal Magistrate Court at Githunguri, after she was defiled by a young man a month before presentation.

After the defilement ordeal, Jane was taken to Kiambu District Hospital where she was put on a post exposure prophylaxis regimen for 2 weeks and was found to be 4 months pregnant (she is a primi-gravida). There was no further clinical follow-up. On further enquiry, Keziah reported that Jane had a long-standing, 1 year history of repeated defilement for the past 1 year. Keziah reported no overt changes in Jane's mood however, Jane had since avoided men as well as leaving the house on her own. She also reported that Jane had developed an exaggerated startle response where she wets herself. She adds that Jane's concentration had decreased.

Jane's father is deceased and her mother went to Saudi Arabia 3 years ago after she and her family were chased away from her matrimonial home. Jane's eldest brother abuses alcohol, cigarette and miraa. Keziah reported that there is no history of mental illness in Jane's nuclear and extended family that she knew of. As she grew up, Jane achieved her developmental milestones very late. She started talking at 16 years of age and toilet-training at 17 years of age. Jane has always liked the company of children who are way younger than herself (2 – 3 years). Her school performance was very poor and she has been in 3 different schools and is still in class 1. Her play is of the parallel category.

Jane is reported to have never abused any psychotropic substances. She is well taken care of by Keziah, her primary caregiver.

On Mental Status Examination, Jane would smile spontaneously for no apparent reason. Her conversation and speech was significant for retardation, low tone, moderate slurring and passive one word answers to very few questions. Her thought process was significant for poverty. She appeared euthymic but her affect was restricted and incongruent to the conversation content. She was not oriented in place and time, her concentration and memory were poor and her intelligence was very low.

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She has no insight and is meant to start antenatal clinic visits. Her intellectual disability, teenage pregnancy and a dysfunctional family confer on her a poor prognosis.

MULTIAXIAL DIAGNOSIS

AXIS I: ACUTE POST TRAUMATIC STRESS DISORDER (DSM IV CODE 309.81)

Jane meets the DSM-IV diagnostic criteria for Acute Post-Traumatic Stress Disorder

- a) She has been sexually defiled repeatedly for 1 year. This is a traumatic event for a young girl
- b) She displays intense distress when she meets with men or asked to leave the house alone.
- c) She actively avoids interacting with men or leaving the house alone.
- d) She displays a general state of increased arousal characterized by her poor concentration and an exaggerated startle response (she wets herself)
- e) Symptoms have persisted for 1 month now (7th/9/2016 – 10th/10/2016)
- f) Symptoms cause significant impairment in social functioning since Jane no longer goes to play with other children.

AXIS II: MENTAL RETARDATION, SEVERITY UNSPECIFIED (INTELLECTUAL DISABILITY)

Jane meets the DSM-IV diagnostic criteria for Mental Retardation

- a) She has significant sub-average intellectual functioning
- b) She has concurrent impairments in adaptive functioning in communication, self-care, interpersonal skills, functional academic skills, safety and self-direction.
- c) The onset was before 18 years of age.

AXIS III: NO GENERAL MEDICAL CONDITION.

AXIS IV: ENVIRONMENTAL FACTORS AND PSYCHOSOCIAL STRESSORS INCLUDE:

- Repeated defilement
- Teenage pregnancy
- Dysfunctional family
- Poor academic performance

AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING SCORE OF 15

Jane has shown failure to maintain her personal hygiene and is virtually unable to communicate with others.

MANAGEMENT

INVESTIGATIONS

1. Biological

- **Blood studies**
 - Complete Blood Count with differential.
 - Blood group and antibody screening.
 - Infection screening: Syphilis serology (VDRL), HIV testing, Hepatitis B testing.
 - Fasting Blood Sugar
- **Urinalysis and infection screening to rule out urinary tract infections.**
- **Pap Smear Test.**
- **Imaging**
 - Ultra-sound scans

2. Social investigations

- Social Worker's intervention.

TREATMENT

1. Psychiatric assessment
2. Link to Sexual Gender Based Violence (SGBV) center for follow up.
3. Start Antenatal Clinic follow up.
4. Social Worker's intervention.
5. Pharmacotherapy
 - **Sertraline** 50mg, PO qDay.
6. Psychotherapy, behavioral therapy and family therapy as adjuncts to pharmacotherapy.

PROGNOSIS

- Poor prognostic factors
 - Intellectual disability
 - Teenage pregnancy
 - Dysfunctional family
- Good prognostic factors
 - Good relation with primary care-giver.
 - Financial support from mother.
- Therefore, she has a poor prognosis.