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Nursing care in bipolar disorder – case study

Wiesław Kowalewski[1], Tamara Walczak-Kozłowska[2, 3, A] ✉, Elżbieta Walczak[4, B], Dorota Bikun[5, C]

[1] State University of Applied Sciences in Koszalin, Department of Nursing, Leśna 1, 75-582 Koszalin, Poland
[2] University of Gdansk, Institute of Psychology, Jana Bażyńskiego 4, 80-309 Gdańsk, Poland
[3] Gdansk University of Physical Education and Sport, Department of Psychology, Kazimierza Górskiego 1, 80-336 Gdańsk, Poland
[4] State University of Applied Sciences in Koszalin, Department of Pedagogy, Leśna 1, 75-582 Koszalin, Poland
[5] Medison Mental Health Clinic, Zwycięstwa 119, 75-601 Koszalin, Poland

[A] ORCID: 0000-0002-9781-7281; [B] ORCID: 0000-0002-4697-2935; [C] ORCID: 0000-0001-5677-5866

✉ walczak.tamara@gmail.com

ABSTRACT

Introduction: Bipolar disorder is a mental illness in which patients often display a significantly disturbed mood and behaviour. Symptoms of mania (one pole of the disease) include a euphoric mood, racing thoughts and agitation, while symptoms of depression (the other pole of the disease) include a depressed mood, reluctant attitude, and impaired thinking or even suicidal thoughts. Therefore, a patient with bipolar disorder is a special challenge for the medical staff in the psychiatric ward.

Materials and methods: The study presents a theoretical background for the problems associated with bipolar disorder and the biggest challenges facing the care team. The work has been supplemented with a case study of a patient along with a nursing care program which was proposed and then implemented.

Results: Implementing the proposed care program by medical care personnel positively influenced the symptoms of bipolar disorder in the presented case.

Conclusions: Throughout the nursing process, it is worth determining the nature of the problems that accompany the patient's disorder, as well as designing an action plan for working on them and any ongoing changes in behaviour and emotions.

Keywords: bipolar affective disorder; nursing care; case study; mood disorders; affective disorders.

INTRODUCTION

Bipolar disorder and unipolar disorder (i.e. recurrent depressive disorder) constitute a group of disorders referred to as "affective disorders" or "mood disorders" [1]. The first one is characterized by at least 2 occurrences where a significantly disturbed mood and activity are observed in the patient. Clinicians characterize these episodes by behavior displaying increased affection, manifestations of mania and hypomania (i.e. increased energy and activity), as well as an emerging low mood accompanied by depression (decreased energy and activity). Both of these very diverse episodes usually follow each other with a certain break for recovery, although this may not occur in all patients. The occurrence of life events or traumas that may precede the recurrence of the disease are quite common, however, such information is not necessary for the diagnosis [2].

In contrast to bipolar disorder, unipolar disorder is characterized by recurring phases of depression without manic episodes [1]. In rare cases, bipolar disorder occurs with episodes of mania without the depressive episodes. In this case, type II bipolar disorder with recurrent manic episodes is diagnosed – F31.8 according to International Classification of Diseases (ICD-10).

The analysis of epidemiological indicators indicates that bipolar disorder affects both men and women in almost equal proportions. Manic episodes usually start suddenly (with mania frequently preceded by milder episodes of hypomania) and last for approx. 4 months (diagnosis is made when the symptoms are maintained for at least 2 weeks). Depressive episodes usually last about half a year and, with the exception of the elderly, do not last longer than a year. However, both the frequency of occurrence of individual episodes and the clinical picture of remissions and relapses changes over time, e.g. shorter remission periods are observed and, in the case of middle-aged patients, relapses of depressive episodes are prolonged and may occur more frequently than in younger patients [2].

In the IICD-10, bipolar disorders have the code F31 whereas recurrent depressive disorders have the code F33. There are several subtypes of bipolar disorder (F31). The first 3, F31.0, F31.1 and F31.2, directly concern a manic episode (with or without psychotic symptoms, i.e. delusions and hallucinations). The classification distinguishes manic episodes and hypomania (of lighter intensity, without the occurrence of hallucinations and delusions). The next 3: F31.3, F31.4, F31.5 refer to a depressive episode of varying severity (from mild to moderate to severe, which may include psychotic symptoms). Coding categories F31.6–F31.8 refer to mixed states, remission states and undefined forms of the disorder (F31.9) [2, 3].

Symptoms and differentiation

Patients diagnosed with bipolar disorder experience changing and extremely different poles of the condition that affect all spheres of their lives. They experience both depressive states causing a low mood and apathy as well as disorders in thinking or even suicidal thoughts, and manic states which cause a euphoric mood, racing thoughts and agitation [3].

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Depression syndrome

Depression syndrome occurs in the course of affective diseases, both in bipolar disorders and in recurrent depressive disorders. The clinical picture contains a number of characteristic features called basic features or axial symptoms [4]:
- low mood,
- reduced physical and mental activity,
- disturbances in biological rhythms and somatic symptoms,
- fear and anxiety.

The drop in mood manifests itself in the form of general sadness and depression as well as feelings of apathy. The appearance of anhedonia, which is a lack of ability to feel pleasure and joy, is a key symptom in the initial diagnosis of depression. It also occurs in schizophrenia and other mental disorders [5]. The inhibition and weakening in the pace of mental processes is characterized by slower thinking, reduced intellectual efficiency and efficiency of memory processes, as well as direct motor inhibition. The motoric slowdown is often connected with a lack of motivation to act. These symptoms are often accompanied by a general feeling of anxiety [6]. Patients with depression syndrome usually experience disturbances of daily rhythm, both in their daily life and sleep patterns. Such problems may manifest themselves in 2 characteristic forms. In the 1st of them, patients experience a significant decrease of time spent asleep in a 24-hour period, as well as a shallow sleep. They often wake up at night and get up early. The 2nd form is characterized by a significantly increased need for sleep. Sleepiness is noticeable during the day despite having slept all night (so-called hypersomnia). This type of sleep disturbance is accompanied by problems with appetite, which results in a reduction in the patient's body weight [5]. Anxiety occurs in the majority of patients in depressive states. It is often called free-floating anxiety due to the fact that it persists almost constantly while displaying a variable (wavy) intensity at the same time. Over time, it may reach a significant level and manifest itself through anxiety attacks and panic states [7].

The fear and constant anxiety of the patient is a state commonly referred to as a depressive world view. It is characterized primarily by negative self-esteem and negation of one's own behaviour. There may also be depressive judgments, a pessimistic approach to life and everyday matters, negative self-perception in the past and lack of a positive vision of the future and any prospects. Moreover, due to the constant feeling of guilt and anxiety, patients lose their passions, are not interested in the world, feel victimised, return to and focus on depressive experiences and feel tired [8]. The consequence of this is that patients suffering from depressive syndromes often lose or weaken their contact with family and close friends. Some patients are also incapable of working, and in extreme cases – of performing domestic duties. Isolation from their surroundings and a constant feeling of anxiety and fear can, in many cases, lead to suicide attempts. Moreover, a high level of anxiety, frequent insomnia, somatic diseases or abuse of psychoactive substances also contribute to a high percentage of excess-mortality of patients. The highest suicide attempt rates are found for men aged 20–30 and over 45, and for women aged 40–60. The most frequent determinants and prerequisites are:
- chronic guilt, hopelessness and helplessness,
- distortions of concentration and mental processes,
- insomnia and disturbances in daily rhythm,
- abuse of psychoactive substances,
- a close friend or family member dying due to suicide,
- previous suicide attempts by the patient [9].

Manic syndrome

Manic syndrome is the "other pole" and the opposite of depressive syndrome in bipolar disorder. Mania includes a group of symptoms that show an analogous pathogenetic background for mania and depression syndrome [10]. Here, the clinical picture also comprises axial symptoms, which include:
- elevated mood,
- increased physical and mental activity,
- disturbances in biological and physiological rhythm.

The elevated mood is manifested primarily by constant well-being, a state of joy, satisfaction, happiness or euphoria. Patients do not feel sad or depressed, as is the case during a depressive state. The characteristic feature of this episode is the occurrence of behaviours inappropriate to a situation. In some cases, irritability and irritation may occur. The patient manifests so-called manic excitement, which is expressed through racing thoughts, mental acceleration, brilliance, quick thinking and a multitude of ideas. On top of that, the patient may display logorrhoea and an acceleration in the pace of thoughts. Patients mention the serenity accompanying them in everyday life and point to a subjective sense of euphoria. In severe mania, it is noticeable that the patient gets angry quickly, is quarrelsome and hates objections. An increase in motor activity is observed. The patients themselves speak of inexhaustible energy, hyperactivity, the inability to sit down and a very strong feeling of excitement [11]. Apart from excessive psychomotor agitation, there are also disturbances to the sleep and wakefulness rhythm. There is a significantly reduced need for sleep, although this does not negatively affect the patients' mood. Despite only sleeping for a short period, they are usually rested and full of energy. Mania is a serious disorder, and it is a clear dysfunction of the body, so in severe cases hospitalization is required. In syndromes called hypomania, all symptoms are less severe, patients declare a cheerful mood, are less irritable, quarrelsome or aggressive [9].

Patients in the course of mania have an increased number of thought processes. They are often more talkative, curious and inventive. Their self-esteem and self-confidence increase and self-criticism disappears. An increased energy for life, mental and physical activity, and a multitude of ideas are recorded. In hypomania, these symptoms are not as intense and people in this state can be perceived positively by their peers as more productive etc. In the case of intensified mania, there is disorganization: stimulation causes logorrhoea and racing thoughts. Patients often start several sentences at once and do not finish them, jumping from one thought to another [10]. Patients become quarrelsome and do not like opposition and criticism. A lack of insight is observed, they cannot objectively look at themselves and their awareness of the disorder disappears. There is also an impulsivity which manifests itself in many

ways, especially with making rash decisions about finances, relationships or relations. The patient may spend large sums of money, start new relationships and end old ones, have casual sex or abuse alcohol or psychoactive substances [9].

Manic syndromes, due to their symptoms, are additionally divided into 3 types:

— dysphoric mania, which is characterized by quarrels. The patient does not tolerate opposition and may manifest aggression and anger. In addition, people in a manic state with dysphoria are irritable and quickly get annoyed,

— euphoric mania, in which patients are cheerful and joyful. They seem to be full of life, happiness and euphoria. They are talkative and positive about the world,

— hyperactive mania, which is usually called acute/heavy mania or manic frenzy. Patients manifest violent behaviour, aggression and are very agitated. A breakdown of cognitive processes is described. In extreme cases mental disorders such as delirium and grandiosity can be manifested [12].

A mixture of these types (F31.6) occurs in about 30% of patients with diagnosed affective disorders and usually indicates a severe condition. In this case, the symptoms of depression and mania occur at the same time, e.g., the patient may show an accelerated course of thinking and increased activity while feeling depressed, anxious, and experiencing negative thoughts. These are the most difficult conditions to diagnose due to the very broad spectrum and heterogeneous picture of symptoms. They often resemble an affective disorder with a very rapid phase change, where changes in the patient's mood and drive can be observed up to as much as a dozen or so times a day [11].

Methods of treatment and prevention

The treatment of bipolar disorder should be conducted in a comprehensive manner and should be a collaboration of interdisciplinary teams (doctor, nurse, psychologist and psychotherapist) due to the complexity of the psychopathological disorder. It should therefore cover pharmacotherapy, community care and all psychotherapeutic activities. The simultaneous use of all these methods shows the highest effectiveness of treatment [13].

The treatment is divided into 3 stages: preventive treatment, treatment of acute depressive episodes and treatment of acute manic episodes. The first one uses medicines that reduce the severity of symptoms of mania or depression and prevents the recurrence of episodes – the so-called normothymic drugs. Lithium salts and antiepileptic drugs such as carbamazepine and sodium valproate are primarily used. Lithium prophylaxis shows the best results in patients with classic forms of the disease. Moreover, the use of lithium significantly decreases the risk of suicide in patients. Carbamazepine and valproate derivatives are used in atypical forms of the condition and in cases where rapid phase changes are diagnosed. Moreover, in recent years other antiepileptic drugs have also been used, such as lamotrigine and newer neuroleptics [9].

The treatment of depression in bipolar disorder is carried out with antidepressants. This therapy results in a certain percentage of cases where depression switches to mania. This is particularly true for tricyclic drugs, which have the highest likelihood of such transitions. Newer generation antidepressants that inhibit noradrenaline and serotonin reuptake are less likely to turn depression to mania. In patients with severe depression, where there is a high suicide risk, electroshock treatment is used. In addition, the parallel use of normothymic and antidepressant drugs is recommended [6].

The treatment of manic episodes is carried out with new generation neuroleptics and normothymic drugs. Classical neuroleptics such as phenothiazine and haloperidol derivatives are also used. Additionally, benzodiazepines are administered in cases of sleep disorders and in order to calm the patient down. If it is possible to administer drugs orally, the supply of second-generation antipsychotics is recommended due to fewer side effects. In the case of hypomania alone, monotherapy with normothymic drugs or new generation neuroleptics is sufficient [14].

It should be added that the treatment of bipolar disorder clearly distinguishes between the treatment of depressive phases, manic phases and the prevention of relapse. The main medicine used in prophylaxis is lithium salts, whose effectiveness is estimated at more than 60%. The choice of treatment for depression in bipolar patients is difficult. The first step is to assess whether the patient is suitable for outpatient treatment or whether hospitalization is necessary. This decision is made based on the patient's condition, type and severity of depression or mania and most importantly – suicide risk [15]. Health care can be provided in 3 forms:

— outpatient treatment. This is mostly provided in mental health clinics. It includes contact with a doctor once every few weeks for patients in partial or full remission,

— daytime treatment. The main advantage of this treatment is frequent contact with the doctor while staying in a home environment. It takes the form of group psychotherapy. Moreover, the treatment is also based on cooperation between the therapist and the patient's family,

— inpatient treatment. This is conducted in psychiatric hospital wards, the patient is under constant supervision of the doctor, and the treatment is continuous. The inpatient system is used for both patients with severely intensified manic and depressive episodes and for patients with suspected bipolar disorder.

The role of nursing care for patients with bipolar disorder

The main problems encountered in patients with bipolar disorder are related to abnormal thinking, and a mood and drive characteristic of a manic or depressive episode. Moreover, side effects of implemented pharmacotherapy may occur [6]. Nursing interventions and activities are aimed at eliminating or reducing the problems identified by the diagnostic team depending on the episode taking place (depressive or manic) [16]. The issues to which attention should be paid in particular are:

— in a manic episode: all aggressive behaviours, disorders of thought and cognitive processes, problems with social relations, perceptual distortions, sleep problems, daily rhythm disorders, eating disorders,

— in a depressive episode: social isolation of the patient, dysfunctional sadness and grief, low self-esteem, helplessness,

powerlessness, disturbances of daily rhythm, sleep disorders, eating disorders and suicide risk,

- all possible side effects resulting from implemented pharmacotherapy.

Patient care during manic syndrome

Nursing intervention and care is, above all, about having an active influence on the patient and their behaviour, but it should also be based on participation and assistance in the therapeutic process. It is very important to focus on activities preventing conflict, on the development and maintenance of communication between the patient and the environment in which they are staying (including building relationships) and surrounding them with empathic support in order to minimize the feeling of loneliness. Nursing staff should show acceptance, give full psychological support as much as possible, and ensure peace and security [12]. In the care of a patient in a manic phase, the priorities should be as follows:

- not applying constant pressure on the patient,
- ensuring a sense of physical and mental security,
- maintaining an appropriate balance in the display of closeness and distance,
- satisfying the basic needs of the patient,
- showing a full understanding of the patient's actions, even if they are not always rational.

One of the most important and difficult things when caring for a patient in a manic episode is ensuring their cooperation in the therapeutic process and helping the patient with self-esteem issues. No unnecessary restrictions should be applied. Direct coercion should only be used in extreme cases of very acute episodes of mania. As well as this, unnecessary discussions or disputes with the patient should be avoided, and the focus should be on clarifying all their doubts regarding the therapeutic process on a substantive and, above all, friendly level [17]. In many cases of manic episodes, it is important to take care of the basic needs of the patient, who in the course of the condition may be too absorbed or distracted by various matters to take care of themselves. Eating and appetite disorders are common and can lead to rapid weight loss and shortages in micronutrients and macroelements. Therefore, it is crucial to constantly monitor the amount and quality of food and fluids consumed. Moreover, it is also important to ensure that the patient maintains proper personal hygiene, which is often neglected in manic episodes [12].

Patient care during depressive syndrome

Nursing actions and interventions during depressive episodes should focus on eliminating and reducing problems in order to minimize the effects of depressive symptoms [5]. The main problems that medical staff encounter when caring for a patient in a depressive state are considered to be the following:

- full or partial social isolation,
- low self-esteem,
- powerlessness and reluctance,
- dysfunctional sadness and grief,
- the possibility of suicide,
- disturbances in thought processes,
- the disruption of all cognitive processes,
- disturbances in daily rhythm and sleep,
- eating disorders.

In the case of patients with acute depressive episodes, suicide risk is considered to be the most important issue. In many cases, hospitalization is necessary, which proves to be the only effective way to deal with the issue. In addition, when observing patients with suspected suicidal thoughts, attention should be paid to their behaviour. Many times, a conversation and questions about any emerging suicidal thoughts can help give the patient a sense of understanding and safety. It is also important to pay attention to whether the patient is taking steps characteristic of people who intend to take their own lives. These include putting their legal and financial affairs in order, writing farewell letters or wills, or inviting close family members to see them – during which, issues related to the possibility of passing and their own death may be bought up [18].

Patients indicate the presence of medical staff as one of the most significant elements of treatment. It is essential to show understanding towards patients while at the same time demonstrating confidence and faith in the treatment the patient is receiving. It is also important not to exert pressure and unnecessary stress, and to avoid advice such as "pull yourself together" or any other signs of a lack of understanding for the person or the condition itself. This is crucial, given that the disorder causes social isolation and the tendency to withdraw and avoid any form of contact with other people. The patients often lose the ability to communicate, have problems with showing their feelings or even talking about them. Moreover, they feel stress and discomfort in any form of social contact with family or medical staff. It is important to promote such contact, but not to the degree where immediate improvement is expected as this can result in the patient feeling a sense of helplessness, regret and being misunderstood [18].

The patient should be encouraged to be active both in terms of communication and physical activity and should be given the opportunity to participate in therapeutic activities or conversations whenever they need them. Moderate physical activities such as walking or doing basic domestic tasks such as preparing a meal are also helpful. It is also important to present the benefits of establishing and maintaining relationships and activities. Behaving in an encouraging and comforting way and talking about future prospects helps to alleviate anxiety and stress [15].

Cognitive dysfunctions most often manifest themselves as problems with concentration, making decisions or solving everyday problems. In such cases, it is important to teach the patient to recognize these difficulties and report them to the staff. This leads to being able to adequately assess reality and easier acceptance of the patient's condition. In the case of affective disorders, it is helpful to provide as few strong external stimuli as possible, to have calm, therapeutic conversations and to show understanding (empathy) [18].

In the case of sleep and daily rhythm disorders, patients should discontinue using all stimulants such as alcohol, strong coffee or tea. It is also important to put emphasis on getting up and falling asleep at fixed times, as well as avoiding naps during the day. The patients should also be advised to take proper care of personal hygiene [16].

The role of the nurse in mitigating side effects of pharmacotherapy

Pharmacological therapy is, in most cases, an essential part of the treatment of bipolar disorder. The combination of psychotherapy and psychoeducation with pharmacotherapy proves to be the most effective treatment. Nursing activities are mainly based on counteracting the side effects of the medication used in the course of bipolar disorder [18].

Nursing interventions for side effects in pharmacotherapy in the course of bipolar disorder include [17]:

— dryness of oral mucosa – firstly, the patient should be encouraged to drink water frequently in small sips. Ice cubes or sugar-free chewing gum can be offered. It is worth stressing that the patient's oral hygiene should be maintained,

— nausea – supplying medicines together with a meal is recommended in order to prevent intestinal and stomach disorders,

— constipation – encouraging the patient to eat meals with a higher fibre content and to drink more fluids. If possible, increase the amount of physical activity during the day,

— urinary problems – persuading the patient to report any problems with urination to a doctor. Keeping a fluid balance,

— orthostatic drops in pressure – instructing the patient not to change position rapidly. Observation of the patient's blood pressure. Informing the patient that it is necessary to avoid hot baths. Reporting any changes in blood pressure to the doctor,

— possibility of seizures – full observation of the patient for seizures. Reporting any changes to the doctor. Conducting an interview to determine the patient's load and the possibility of the occurrence of a seizure,

— arrhythmia – informing the patient about the possibility of changes in heart rate and the need to report this quickly to personnel. Monitoring the patient for current heart rate and blood pressure,

— sensitivity to light – educating patients to avoid exposure to sunlight and to protect their skin and eyes. Recommending the use of sunglasses, sunscreen and long-sleeved clothing,

— blurred vision – informing the patient that the problem is temporary and will resolve itself. Teaching about precautions to be taken when driving a motor vehicle and handling dangerous tools,

— weight gain – suggesting a diet with reduced calorie intake. Encouraging the patient to drink more water and to adjust its amount according to the state of physical activity,

— excessive agitation and insomnia – it is recommended to take medicines in the morning, if possible, so that they do not interfere with the biological rhythm of the day. Educating the patient to avoid drinks and stimulant foods that contain caffeine or plenty of sugar before bedtime. Suggesting relaxation and calming techniques before bedtime,

— headaches – informing the doctor in order to change the drug or its dose. Administering painkillers in accordance with the doctor's order,

— significant weight loss – checking the number of meals and calories consumed by the patient during the day. Daily weigh, adapting the diet. Weight loss often occurs at the beginning of treatment [17].

The aim of this study was to present the process of care for a patient with a diagnosed bipolar disorder. Attention was focused mainly on the analysis of both poles of the condition – depressive and manic. These syndromes have a wide spectrum of symptoms, which makes the activities of medical personnel difficult (including nursing staff). The difficulties relate largely to the identification of the patient's condition and the adjustment of appropriate care practices. Both depressive and manic conditions, due to their course, require different approaches for different patients. Nursing activities differ in every area, from the supply of medications to proper education and psychoeducation and dialogue with the patient. Therefore, the main challenge for medical professionals is to properly diagnose the pole of the disorder, as well as to adjust professional practices depending on the severity of symptoms.

CASE STUDY

The information collected in the course of the research comes from one patient, a male (J.J.) aged 29 years with a preliminary diagnosis of bipolar disorder. Observations and interviews with the patient were conducted in the psychiatric ward between between 8 November and 8 December 2017. Clinical material was collected by means of systematic observations and partially structured interviews. The discussion of problems in nursing care and nursing processes was based on experience from personal psychiatric practice with the support of a literature analysis in the field of psychiatry and affective disorders. Experience and direct contact with patients affected by mental disorders allowed for an objective description of the problem and a deep understanding of the role that must be taken up by the medical staff involved in the process of treatment for patients with affective disorders.

Patient characteristics

The patient was admitted to the psychiatric ward of the city hospital on 8 November 2017 at 10:52 a.m. Following an examination by a team of doctors and psychologists, a preliminary diagnosis of an acute manic episode (F30) was made.

The observation of the patient started from the moment of admission. J.J. was irritable and aggressive and showed an accelerated psychomotor drive. Manic aggravation was observed in the range of mood and propulsion. The patient's statements included imaginary, xenophobic and grandiose contents. His consciousness was clear and his verbal-logical contact was preserved. Moreover, the patient was aware of the place and time. J.J. declared his awareness of the condition and the recurrence of manic episodes. He also agreed to hospitalization and treatment.

The patient was interviewed 2 days after being admitted to the psychiatric ward of the hospital. The interview showed that J.J. was fully aware of his medical condition and knew its course and symptoms, both in manic and depressive episodes. He was not always able to predict and recognize the beginning of a manic episode. The patient stated that the depressive episodes were not severe and that he was able to deal with them on his own. The patient reported that in the family, his

father had been diagnosed with bipolar disorder 10 years earlier – although his case had not been as severe and he was able to manage it much better, remaining socially and professionally active. J.J. states that he is unable to cope with acute relapses of mania and that hospitalization is necessary. The patient characterises manic episodes as being full of aggression and hatred, and in the past they were accompanied by minor theft, binge drinking lasting several days, as well as a significant consumption of cocaine and marijuana. J.J. made several unsuccessful attempts to deal with his psychoactive drug addiction. During the episodes of mania, the patient moved out of his residence 3 times and stayed in hotels or with friends. According to the patient's account, the condition prevents him from taking up permanent employment. J.J. points out that it is very difficult to stay focused (problems with concentration during activities) during episodes of mania, as well as to control racing thoughts. The patient shows a willingness to start treatment, seeing it as a chance to be able to function normally. He is also driven by familial motivations – J.J. feels he is a burden for his family and is afraid that every attack of mania increases the risk of causing physical harm to himself or to third parties. The patient indicates that he would like to function like his father, who deals with the same condition in a better way.

The family interview included a conversation with the patient's mother. Her report shows that J.J. was hospitalized in the psychiatric ward many times, mainly due to acute manic episodes. Patient's mother pointed out that her son did not suffer from concomitant diseases, but she admitted that he was heavily addicted to marijuana. The mother noted that J.J. had been repeatedly aggressive towards family members and other third parties, both verbally and physically. She mentioned a number of police interventions in the patient's place of residence. The mother pointed out that during remission periods, J.J. was aware of his health condition and the need for treatment, as well as the need for hospitalization in the case of manic episodes. She also added that she had not had any contact with her son during the last month, as he had moved out of the house. After his return, she decided to inform the police and the medical emergency services, who made the decision to transport the patient to the psychiatric ward. J.J.'s mother stated that her son caused her great anxiety and fear when manic episodes returned. She fears for the life and health of herself and her family members, who, in her opinion, feel threatened by J.J.'s behaviour during manic episodes. She also points out that J.J.'s extremely aggressive behaviour against family members has occurred many times in the past. She adds that her and her husband, who has the same disorder as J.J., feel helpless in the face of their son's condition which in her opinion is completely different from that of her husband as it is much more severe. Moreover, in comparison to J.J., the patient's father is under the constant care of a psychiatrist, to whom he goes for consultations. He also takes medication which enables him to maintain his professional activity.

Problems to be solved in the process of care

After the diagnosis of the disorder and episode by medical staff, pharmacotherapy was started, a therapeutic plan was prepared and the problems to be worked on during the patient's stay in the ward were identified:

- suicide risk,
- distorted social relations,
- dysfunctional sadness, grief and anxiety,
- disturbed sleep and daily rhythm negatively affecting the patient's functioning,
- eating disorders,
- disturbed cognitive function and thought processes.

The process of care

Problem 1: suicide risk

Care objectives: preventing suicide attempts, reducing the frequency and intensity of recurring suicidal thoughts.

Care plan:

- permanent observation of the patien,
- removal of any hazardous objects from the patient's environment,
- limitation of strong external stimuli,
- supporting conversation with the patient,
- psychoeducation on how to deal with recurring self-destructive thoughts and offering help and opportunities to talk whenever the patient feels the need,
- ensuring a psychotherapist is available to him,
- enabling participation in group therapy and contact with the family,
- encouraging light activities, e.g. outdoor walking,
- supply of medication as recommended in the case of recurrent anxiety or panic attacks.

Assessment: the patient states that suicidal and self-destructive thoughts are less persistent. He is more open and eager to talk with medical staff. Additionally, the patient declares that he has someone to live for and is still young. He is able to rationally explain where suicidal thoughts come from and react to them with critical thinking.

Problem 2: distorted social relations

Care objectives: assisting the patient with the ability to critically evaluate his own behaviour, improving the ability to maintain interpersonal relations.

Care plan:

- acceptance and openness when talking to the patient. Showing empathy and understanding for his situation,
- frequent contact and help in establishing relations,
- assuring the patient that he can talk to the therapeutic team whenever the need occurs,
- showing the patient how he is advancing in therapy,
- maintaining the patient's motivation to continue therapy and development,
- ensuring the patient knows that he can voice any feelings and worries,
- encouraging the patient to take part in group psychotherapy, group activities and all other activities organized in the ward,
- psychoeducation regarding ways of dealing with recurring and intensified anxiety,

— practicing techniques of calming thoughts, mindfulness and relaxation,

— help in choosing activities most suited to the patient and supporting his therapy,

— in cases of intensified anxiety, administering anti-anxiety medication as ordered by the doctor,

— full observation of the reaction to pharmacotherapy.

Assessment: despite recurring anxiety the patient decided to join group therapy. He is increasingly willing to establish contact with other patients. He maintains constant telephone contact with members of his immediate family.

Problem 3: dysfunctional sadness, grief and anxiety

Care objectives: teaching the patient to deal with depression and anxiety.

Care plan:

— emphatic conversations with the patient and building trust,

— encouraging the patient to talk frankly and freely, openness to his various feelings and emotions,

— encouraging contact with the therapeutic team as frequently as possible,

— education regarding recurring psychotic symptoms: supporting positive thinking and good self-esteem; cognitive explanations of anxiety, sadness and grief; acceptance of symptoms that cannot be eliminated; focusing thoughts and attention on positive aspects of life and memories,

— encouraging the patient to develop hobbies or activities that bring him satisfaction and joy,

— the offer of constant contact with the therapeutic team,

— establishing an optimal daily rhythm for the patient and help in maintaining it,

— motivating the patient to undertake further actions aimed at dealing with negative emotions,

— educating the patient's family in early diagnosis of recurrent dysfunctional thoughts.

Assessment: family members were informed of the 1st symptoms of recurring destructive and dysfunctional thoughts. They know how to react and where to look for help. The patient is clearly absorbed with learning English in his free time, which, as he states, has always been his passion. He plans to go abroad in order to get to know the culture of English-speaking countries.

Problem 4: disturbed sleep and daily rhythm negatively affecting how the patient functions

Care objectives: Achieving and maintaining an undisturbed sleep. As time goes on, discontinuing sleep-inducing medication. Normalizing daily rhythm.

Care plan:

— recognizing the causes of disturbed sleep and considerable problems with falling asleep,

— providing proper conditions for peaceful and undisturbed sleep,

— educating the patient on relaxation and calming methods conducive to a good night's sleep,

— informing the patient of the necessity of limiting the consumption of excessive amounts of sugar, caffeine and energising meals and drinks,

— limiting daytime naps (both in frequency and duration),

— planning daily physical activities,

— creating a proper microclimate in the bedroom, temperatures in the range of 18–21°C, proper humidity and a supply of fresh air,

— administering sleeping pills in accordance with the doctors' orders and a full observation of the reaction to pharmacotherapy.

Assessment: despite discontinuing watching TV and using a mobile phone up to 3 h before bed, there are still problems with disturbed sleep. The patient claims to wake up about 5–6 times a night. He feels less tired but still has trouble sleeping. He still thinks he cannot function without an hour's nap during the day. The creation of a suitable microclimate in the patient's room resulted in the patient no longer needing sleeping pills. The patient claims that going for a walk before bedtime helps him to fall asleep. The patient stopped consuming coffee after 4 p.m.

Problem 5: eating disorders

Care objectives: maintaining proper body weight. Supplementing macro- and micronutrients adequately. Preventing sudden weight loss.

Care plan:

— checking the patient's weight every day,

— providing a properly balanced diet adapted to the patient's metabolic needs,

— encouraging the patient to consume meals in accordance with the suggested diet,

— explaining the importance of proper nutrition and the number of factors it influences,

— checking the number of meals consumed, noting down results,

— where possible, composing the meals to the patient's taste,

— providing the patient with the right conditions and time necessary for stress-free meals,

— education on the necessity of oral hygiene before and after meals,

— encouraging the patient to drink a proper amount of fluids according to his needs.

Assessment: despite the initial weight loss after being admitted to hospital, the patient is not currently losing weight. He eats regularly, dividing portion sizes to eat more often. The patient seems to have more energy and states that, during the day, he is not as sleepy as he used to be when he ate too much at once. He complements his diet with natural, non-sweetened juices supplied by his mother, ca. 500 mL daily. The patient does not have any problems with bowel movement.

Problem 6: disturbed cognitive function and thought processes

Care objectives: control over racing thoughts. Assistance in restoring the ability to evaluate reality properly. Education in the field of recognition and assessment of problems concerning irregularities in the course of thinking and cognitive processes.

Care plan:

— education in recognizing the first signs of disturbances in thinking,

— providing the patient with an environment with a limited number of stimuli,
— presenting techniques for the verbalization of thoughts,
— ensuring the patient is not isolated in the event of a recurrence of the disturbances,
— support and being present in cases of delusion or thought disturbances,
— due to his narrowed perception, communication with the patient should be characterized by short messages, without unnecessary polemics,
— pharmacotherapy as instructed by the doctor and presentation of the benefits of the supply of medicines to the patient,
— making the patient aware that the condition is temporary and that the symptoms should disappear after medicatiom.

Assessment: the patient manifests recurrent disorders in the course of thinking through the form of logorrhoea, racing thoughts and problems with the content of thoughts (pronounced content of delusional and grandiose character). The patient claims that he also has problems with concentration and decision making. However, it has been observed that during relapses of his symptoms, he willingly talks and consults with the therapeutic team.

CONCLUSIONS

In the process of treating a patient with bipolar disorder, the role of nursing staff is extremely important and irreplaceable. Nurses remain in constant contact with the patient. The nurses care procedures, relationship and the method of communication influence the psychological comfort and sense of security in the patient as well as how well they acclimatise to their new surroundings. The nursing staff of the psychiatric ward should build the patients trust in the medical and therapeutic team as this is one of the most effective ways to achieve the desired effects of treatment.

It is important to formulate a proper treatment plan based on the diagnosed problems associated with bipolar disorder. A clear definition and indication of specific practices makes it easier for all members of the medical staff working with the patient to comply with them. In order to obtain a complete and comprehensive diagnosis of the psychiatric patient, it is necessary to conduct a full interview and observe the patient during their stay. It is necessary to evaluate many components of the patient's condition, such as: disturbances and problems in playing life roles, social dysfunctions, problems in relationships with close family, the patient's willingness to cooperate with staff (level of motivation and involvement), as well as systematic care for hygiene and proper nutrition. Moreover, one of the most significant tasks is to gain the patient's trust. A nurse is the only person who participates in and is able to evaluate all these processes which have a major impact on treatment.

In addition to professional skills and knowledge, the ability of nursing staff to build trust in patients and their families is equally important. In order to understand the patient, many aspects and factors need to be taken into account that require an empathetic approach. This starts with getting the patient out of the home and professional environment, separating them from their family and the fear of hospitalization and ends with the limitations of satisfying basic life needs. The main task of the therapeutic team is to show empathy, understanding and a willingness to help. It is also important to strengthen the patient's resources, self-confidence and motivation for treatment.

It should also be taken into account that people working with psychiatric patients are particularly exposed to stress, psychological tension and uncertainty about the behaviour of the patient. The work of a nursing team in a psychiatric environment is one of the most difficult areas that can be chosen by someone taking their first steps in this profession. This is due to constant stress, emotional exhaustion and/or a subjective impression of low professional competences. The education of a psychiatric nurse takes many years and is extremely demanding. A trainee nurse should show openness, and high levels of empathy and understanding. Despite the difficulties and demands of the psychiatric ward on its staff, nurses are often satisfied with their work. Each day, cases differ significantly from one another and routine is uncommon. Each patient is a separate book, written with a history of experiences, emotions, feelings and events that have shaped the person.

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