



## Caring for a person experiencing *Mania*

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### Case study

Yousef is 40. He has been brought to the emergency department with cuts to his arms, chest and face, which he received as a result of a fight in a bar. His friend has advised that Yousef has bipolar disorder, and that he looks like he is 'on the way up'.

Staff have concluded that a psychiatric assessment of Yousef is needed to determine whether admission for psychiatric reasons is required. Yousef is to be kept in the emergency department until this can be arranged, which could be several hours. During this time, he finds it extremely difficult to stay in bed and is constantly wandering around the ward into other rooms. When he is in bed, Yousef is constantly ringing the buzzer. He is frequently found talking to other patients, staff and visitors about his wonderful new invention and trying to get them to invest in a company that he is planning to set up.

The following information could help you nurse a patient like Yousef.

### What is mania?

Mania is a state of extreme physical and emotional elation.

### Symptoms and types of mania

A person experiencing mania or a **manic episode** may present with the following symptoms:

- ◆ **Elevated mood.** The person feels extremely 'high', happy and full of energy; he or she may describe the experience as feeling on top of the world and invincible. The person may shift rapidly from an elevated, happy mood to being angry and irritable if they perceive they have been obstructed.
- ◆ **Increased energy and overactivity.** The person may have great difficulty remaining still.
- ◆ **Reduced need for sleep or food.** The person may be too active to eat or sleep.
- ◆ **Irritability.** The person may become angry and irritated with those who disagree with or dismiss his or her sometimes unrealistic plans or ideas.
- ◆ **Rapid thinking and speech.** The person's thoughts and speech are more rapid than usual.
- ◆ **Grandiose plans and beliefs.** It is quite common for a person in a hypomanic or manic state to believe that he or she is unusually talented or

gifted or has special friends in power. For example, the person may believe that he or she is on a special mission from God.

- ◆ **Lack of insight.** A person in a hypomanic or manic state may understand that other people see his or her ideas and actions as inappropriate, reckless or irrational. However, he or she is unlikely to personally accept that the behaviour is inappropriate, due to a lack of insight.
- ◆ **Distractibility.** The person has difficulty maintaining attention and may not be able to filter out external stimuli.

Episodes that are characterised by the above, but are not associated with marked social or occupational disturbance, a need for hospitalisation or psychotic features are called **hypomanic episodes**.

### Causes, onset and course of mania

A person may experience mania as a result of a range of factors, including:

- ◆ stressful events
- ◆ genetic factors
- ◆ biochemical factors (neurotransmitter abnormalities or imbalances)
- ◆ seasonal influences
- ◆ bipolar affective disorder (BPAD).

For individuals living with bipolar affective disorder (also called bipolar disorder and formerly called manic depressive psychosis) they will experience recurrent episodes of depression and mania, of which the symptoms are not due to substance use or other general medical conditions. The manic or depressive episodes are usually separated by lengthy periods where the person is well.

The average age for the first manic episode is in the early twenties; however, for some, episodes begin in adolescence. The first episode rarely occurs after the age of 50. Manic episodes in adolescence are more likely to include psychotic features and may be associated with school truancy, antisocial behaviour, school failure or substance abuse. Lifetime prevalence is about one per cent.

Manic episodes begin suddenly and with a rapid escalation of symptoms over a few days. They may follow psychosocial stressors or a major depressive episode.

### Difficulties in diagnosis

Symptoms similar to those in a manic phase may be due to the effects of antidepressant medication, electroconvulsive therapy or medication prescribed for other physical illnesses (for example, corticosteroids) and are not included in this diagnostic category. Be aware co-occurring substance use disorders are common and engage in routine screening and assessment.

#### A person's perspective on what it is like to experience mania

'I am feeling ten foot tall, bulletproof and experiencing a high I'd imagine you could attain only on the strongest drugs. I place my head in my hands and my mood starts morphing from hilarity into a cosmic scramble of visions from history.'

*Craig Hamilton in Broken Open*

## Some reported reactions to people experiencing mania

Nurses who have worked with people who have mania have reported the following reactions:

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| <b>Amusement</b>     | It is quite common for staff to react to the person's acting out and exuberance with amusement. It is important to ensure that respect for the person is maintained at all times.  |
| <b>Irritation</b>    | A person experiencing mania might not be compliant with hospital routines or personal health care. This can cause nurses to feel irritated or even angry with the person.  |
| <b>Embarrassment</b> | Some nurses report feeling embarrassed at what they perceive as an apparent lack of control in the person's behaviour. This embarrassment can be particularly acute if this behaviour is conducted in the presence of others, who might expect the nurse to intervene. |
| <b>Discomfort</b>    | When a person is manic, he or she can sometimes be verbally abusive and make personally demeaning comments. This can cause further distress among staff, who may feel uncomfortable nursing the person.  |

## Goals for nursing a person experiencing mania

Appropriate goals for caring for a person with mania in a community or hospital setting include:

- ◆ Develop a relationship with the person based on empathy and trust.
- ◆ Ensure that the person remains free from injury.
- ◆ Assist the person to decrease their agitation and hyperactivity.
- ◆ Promote an understanding of the features and appropriate management of mania, such as mood regulation strategies or behaviours.
- ◆ Promote positive health behaviours, including medication compliance and healthy lifestyle choices (for example, diet, exercise, not smoking etc.).
- ◆ Promote the person's engagement with their social and support network.
- ◆ Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- ◆ Support and promote self-care activities for families and carers of the person with mania.

## Guidelines for responding to a person experiencing mania

- ◆ If appropriate, arrange for a review of the person's medication for mania and an initial or follow-up psychiatric assessment if their care plan needs reviewing. A mental health assessment may be appropriate to undertake — see the MIND Essentials resource 'What is a mental health assessment?'
- ◆ A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is essential to take this into account when formulating diagnosis and care plans. Indigenous mental health workers or multicultural mental health coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre are available for advice and assistance in understanding these issues.

For more information visit [www.health.qld.gov.au/pahospital/qtmhc/default.asp](http://www.health.qld.gov.au/pahospital/qtmhc/default.asp)

- ◆ Tell the person what is expected of him or her, but be realistic. For example, if the person needs to pace, facilitate this in an area that does not disrupt others. Encourage respect for the personal space of others, and also show respect for the person experiencing mania.
- ◆ Encourage and support any ideas the person has that are realistic and in keeping with his or her healthcare regime.
- ◆ It is possible for people to experience a mixed episode in which mood can alter rapidly between euphoria, sadness and irritability. Suicidal thoughts and psychotic features may be present. Ensure your ongoing assessment includes asking about thoughts of self-harm and suicide.
- ◆ Provide the person with consistent limits. Make sure all staff are clear about these and that they reinforce set limits. Give the person clear, simple directions. It is far more effective to suggest alternative strategies, because the person will be easily distracted, rather than directly forbid an action.
- ◆ Encourage the person to organise and slow his or her thoughts and speech patterns, by focusing on one topic at a time and asking questions that require brief answers only.
- ◆ If his or her thoughts and speech become confused, try to cease the conversation and sit quietly together to help him or her calm down.
- ◆ Avoid verbal confrontations with the person, who is likely to have minimal tolerance.
- ◆ Limit the person's interactions with others as much as possible and remove any external stimulation (for example, noise) where possible. Attempt to provide an area that is private, quiet and dimly lit. However, be careful to avoid completely isolating the person.
- ◆ Encourage the development of regular sleeping patterns, and remove distractions during normal sleeping periods.
- ◆ Monitor recovery, compliance with medication and general physical health (including nutrition, weight, blood pressure etc). Provide education on possible side effects to any mood stabilising medication (such as lithium carbonate or sodium valproate) and work with the person to develop appropriate actions to address any issues.
- ◆ If lithium has been prescribed, be aware of signs of toxicity (for example, vomiting, diarrhoea, tremors, drowsiness, muscle weakness and/or ataxia). Lithium has a narrow therapeutic margin and requires regular monitoring of blood levels.
- ◆ The person may find it hard to sit down long enough to take adequate food and fluids. Offer food and drinks that can be taken 'on the run', such as sandwiches. It is important to monitor fluid intake, especially if lithium has been prescribed, because dehydration will exacerbate lithium toxicity.
- ◆ Provide family members and carers with information about mania if appropriate, as well as reassurance and validate their experiences with the person. Encourage family members and carers to look after themselves and seek support if required.
- ◆ Be aware of your own feelings when caring for a person experiencing mania. Arrange for debriefing for yourself or for any colleague who may need support or assistance — this may occur with a clinical supervisor or an Employee Assistance Service counsellor.

The Employee Assistance Service provides confidential, short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit <http://qheps.health.qld.gov.au/eap/home.htm>

## Treatment of mania

Careful assessment to rule out organic conditions is an important first step in the management of mania. Often hospitalisation is required for someone who is experiencing acute mania.

Both mood-stabilising agents such as lithium carbonate or sodium valproate and an antipsychotic may be needed to treat psychotic symptoms, agitation, thought disorder and sleeping difficulties. Benzodiazepines may be useful to reduce hyperactivity. Treatment with lithium alone may have a relatively slow response rate (up to two weeks after a therapeutic blood level is established), so that adjunctive medication such as sodium valproate is usually required. Regular monitoring of blood levels for lithium and valproate is essential because of the potential for toxicity.

Hypomania may be managed with lithium or valproate and benzodiazepines. Doses can be lower than for mania, and may prevent progression to a manic episode.

Maintenance therapy needs to be based on an assessment of severity, recurrences and risks of ongoing use of medication.

Psychosocial strategies including education, counselling and support for the person and his or her family can help with understanding, stress management and compliance with medication.

## Discharge planning

Discuss referral options with the person and consider referrals to the following:

- ◆ GP
- ◆ Community Child Health
- ◆ Community Health
- ◆ Mental Health Services (infant, child and youth or adult)
- ◆ Private service providers

To access the contact numbers and details for your local services use QFinder (available on QHEPS) or call 13HEALTH (13 43 25 84).

## Further reading

For information on antipsychotic medication, see the MIND Essentials resources 'Caring for a person experiencing delusions' or 'Caring for a person experiencing hallucinations'.

See also the Mental Health First Aid Manual at [www.mhfa.com.au](http://www.mhfa.com.au) (internet access required).

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