8.4: Applying the Nursing Process to Bipolar Disorders

Assessment

Assessment of a client with a mood disorder focuses on both verbal and nonverbal assessments. People with a bipolar disorder experience periods of unusually intense emotion, grandiose delusions, changes in sleep patterns and activity levels, and impulsive behaviors, often without recognizing potential harmful effects. [1] See Figure 8.3 [2] for an artistic depiction of grandiose delusions when a cat looking in a mirror sees a lion.
Figure 8.3 Grandiose Delusions

It is often helpful to interview family members or significant others of clients with mood disorders. Clients with mania, hypomania, or psychosis often have poor insight and may have difficulty providing an accurate history.\(^3\)

Safety guidelines for assessing a client with a bipolar disorder include the following: \(^4\)

- Assess if the client is a danger to self or others. The client may have suicidal or homicidal ideation. Poor impulse control may result in harm to self or others. Assess the need for protection from uninhibited behaviors. For example, external controls may be needed to protect the client from consequences such as bankruptcy.
- Assess physiological stability while obtaining vital signs and lab results including electrolytes. The client may not eat or sleep for days at a time with potential physiological consequences.

Mental Status Examination

Table 8.4a outlines typical assessment findings a nurse may observe in a client experiencing a manic episode. Typical findings relate to mood, behavior, thought processes, speech patterns, and cognitive function.

Table 8.4a Typical Mental Status Examination Findings for a Client Experiencing a Manic Episode\(^5\)\(^6\)\(^7\)
<table>
<thead>
<tr>
<th>Assessment</th>
<th>Typical Findings During a Manic Episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Consciousness and Orientation</td>
<td>May be disoriented/confused, but can be oriented to person, place, and time.</td>
</tr>
<tr>
<td>Mood and Affect</td>
<td>Exhibits an unstable, euphoric mood. Client may state they feel “up,” “high,” “jumpy,” or “wired,” but mood can quickly change to irritation and anger.[8] Typically exhibits a decreased need for sleep and a loss of appetite that may result in dehydration or poor nutritional status.</td>
</tr>
<tr>
<td>Appearance and General Behavior</td>
<td>May exhibit inappropriate dress or grooming or dress provocatively, sloppily, flamboyantly, or bizarrely. May change clothes frequently throughout the day. May use excessive makeup or demonstrate little attention to grooming. May demonstrate risky behaviors with poor impulse control and poor judgment, such as eating and drinking excessively, spending or giving away a lot of money, or having reckless sex.[9] Excessive spending can lead to financial hardship from credit card debt from buying items they don’t need.</td>
</tr>
<tr>
<td>Speech</td>
<td>Typically talk very fast (e.g., pressured speech) about many different topics (hyperveral).[10] May have difficulty in accurately communicating needs due to flight of ideas or slurred or garbled speech.</td>
</tr>
<tr>
<td>Motor Activity</td>
<td>Typically hyperactive with an inability to recognize need for rest or sleep.</td>
</tr>
<tr>
<td>Client may state they feel as if their “thoughts are racing.”[11] May feel as if they are unusually important, talented, or powerful.[12]</td>
<td></td>
</tr>
<tr>
<td>Thought and Perception</td>
<td>May describe hallucinations, illusions, or paranoia. May exhibit flight of ideas, loose associations, and clang associations. (See definitions of terms in the “Application of the Nursing Process in Mental Health Care” chapter.) May exhibit suicidal, homicidal, or violence ideation.</td>
</tr>
<tr>
<td>Attitude and Insight</td>
<td>Typically exhibit limited insight with an inability to make sound decisions impacting their adherence to taking prescribed medications.</td>
</tr>
<tr>
<td>Cognitive Abilities</td>
<td>Typically exhibit decreased attention span, distraction, and impaired judgement.</td>
</tr>
</tbody>
</table>
Screening Tools

Many screening tools exist to assess mood disorders. Common examples include the following:

- **Mood Disorder Questionnaire (MDQ) PDF**: Thirteen questions with yes/no responses for assessing mania.

- **Young Mania Rating Scale (YMRS) PDF**: An 11-item assessment based on the client’s subjective report of behaviors over the past 24 hours regarding manic symptoms. It is useful to evaluate baseline functioning and progress being made. There is also a parent version for assessing children and adolescents.

- **Altman Self-Rating Mania Scale**: A self-assessment questionnaire to evaluate the severity of mania or hypomania.

Laboratory Testing

Initial medical evaluation of clients with a possible or established diagnosis of bipolar disorder typically includes the following:

- Thyroid stimulating hormone
- Complete blood count
- Chemistry panel
- Urine toxicology to screen for substances of abuse

Thereafter, routine laboratory testing for clients with bipolar disorders can include these items:

- Therapeutic Medication Levels: Medication dosages may need adjustment based on blood levels to avoid toxicity and ensure they are in therapeutic range. Read more about therapeutic drug levels under the “Medications” subsection of the "Treatments for Bipolar Disorders" section of this chapter.

- Kidney or liver function tests, based on medications prescribed.

- Thyroid function studies and calcium levels.

- Nutrition or hydration status, such as serum sodium levels, hematocrit, albumin, and prealbumin levels, which can become impaired during manic episodes due to poor intake.

Reflective Question

1. What are some common underlying medical conditions that could potentially mimic the symptoms of mania in older adults?

2. Why are some individuals with bipolar disorder misdiagnosed with schizophrenia?

Diagnoses

Mental health disorders are diagnosed by trained mental health professionals using the **Diagnostic and Statistical Manual of Mental Disorders (DSM-5)**. Nurses create individualized nursing care plans using nursing diagnoses based on the client’s response to their mental health disorders. Examples of common nursing diagnoses associated with bipolar disorders are listed in Table 8.4b.
Table 8.4b Common Nursing Diagnoses Related to Bipolar Disorder

<table>
<thead>
<tr>
<th>Nursing Diagnosis</th>
<th>Associated Behaviors and Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety: Risk for Injuries</td>
<td>Impulsive, risky behaviors with poor personal boundaries. Lack of insight into illness. May exhibit agitation, self-harm, or threatening behaviors.</td>
</tr>
<tr>
<td>Communication: Impaired Cognition</td>
<td>Grandiose thinking with poor judgment, flight of ideas, or pressured speech with loose associations.</td>
</tr>
<tr>
<td>Communication: Impaired Communication</td>
<td></td>
</tr>
<tr>
<td>Self-Care Deficit: Bathing, Grooming, Hygiene, Dressing</td>
<td>Poor hygiene and distracted from tasks.</td>
</tr>
<tr>
<td>Impaired Nutrition</td>
<td>Unable to sit long enough to eat; poor appetite. May eat excessive amounts of food during hypomanic episodes.</td>
</tr>
<tr>
<td>Disturbed Sleep Patterns</td>
<td>Inability to rest or sleep without frequent awakenings; often hyperactive at night.</td>
</tr>
<tr>
<td>Fatigue r/t Psychological Demands</td>
<td>Hyperactive and restless.</td>
</tr>
<tr>
<td>Social Isolation r/t Ineffective Coping or Intrusive Behaviors</td>
<td>Feel different from others and preoccupied with own thoughts. Social behavior may be incongruent with norms. May demonstrate an excessive amount of verbal exchange or violation of personal boundaries. May engage in inappropriate sexual language or behavior.</td>
</tr>
<tr>
<td>Risk for Spiritual Distress</td>
<td>Demonstrate ineffective coping strategies, separation from support system, or hopelessness.</td>
</tr>
</tbody>
</table>

Outcome Identification

Outcome criteria are based on the phase of bipolar illness the client is experiencing, either acute or maintenance phase. During an acute manic episode, the overall goals are symptom management, achieving remission of symptoms, preventing injury, and supporting physiological integrity. Examples of goals during the acute phase include the following:

- Maintain stable cardiac status.
- Be well-hydrated.
• Get sufficient sleep and rest.
• Make no attempt at self-harm.
• Demonstrate thought control with the aid of staff and/or medication.
• Maintain tissue integrity.

The maintenance phase occurs after acute symptoms have been controlled and the goals become focused on preventing future exacerbations of manic episodes through education, support, and problem-solving skills. The following are examples of goals during the maintenance phase:

- Identifying and avoiding triggers for developing acute mania
- Attending therapy sessions
- Developing new coping skills

SMART outcomes are Specific, Measurable, Attainable/Actionable, Relevant, and Timely. Read more about SMART outcomes in the "Application of the Nursing Process in Mental Health Care" chapter. The following are sample SMART outcomes for clients with bipolar disorders:

- The client will communicate feelings and thoughts of self-harm (self-injury) to the health care team, prior to acting on thoughts, during this shift.
- The client will eat breakfast within one hour of the arrival of the breakfast tray.
- The client will attend one or more group meetings each day while in the outpatient setting.

Planning Interventions

When a client is hospitalized during an acute manic episode, planning focuses on stabilizing the client while maintaining safety. Nursing care focuses on managing medications, decreasing physical activity, increasing food and fluid intake, reinforcing a minimum of 4 to 6 hours of sleep per night, and ensuring self-care needs are met.

During the maintenance phase, planning focuses on preventing relapse and limiting the severity and duration of future episodes. During this period, individuals with bipolar disorders often face multiple hardships resulting from their behaviors during previous acute manic episodes. Interpersonal, occupational, educational, and financial consequences may occur. Clients need support as they recover from acute illness and repair their lives.

Individuals are often ambivalent about treatment, but bipolar disorders typically require medications to be taken over long periods of time or for a lifetime to prevent relapse. Self-medication through alcohol or other substances often complicates recovery and treatment. Nurses must establish a therapeutic nurse-client relationship to support continued treatment. Individuals are typically referred to community resources and outpatient mental health care settings. In addition to medication management, outpatient services provide structure and decrease social isolation.
Implementation

Common nursing interventions for clients experiencing acute manic episodes are described in the following tables. Table 8.4c describes interventions according to categories in the APNA Standard of Implementation. (Read more about the APNA Implementation Standard in the “Application of the Nursing Process in Mental Health Care” chapter.) Table 8.4d describes nursing interventions to promote physiological integrity. See the “Treatments for Bipolar Disorders” section of this chapter for additional collaborative mental health interventions, including medications and psychotherapy.

Table 8.4c Nursing Interventions for Mania Based on the Categories of the APNA Implementation Standard

<table>
<thead>
<tr>
<th>Categories of Interventions Based on the APNA Standard of Implementation</th>
<th>What the nurse will do…</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination of care</td>
<td>Plan for quality of life, independence, and optimal recovery. Refer to community resources and outpatient mental health care settings.</td>
<td>The nurse coordinates care delivery during inpatient care and for after discharge.</td>
</tr>
<tr>
<td></td>
<td>Maintain safety by communicating safety precautions with interprofessional team members as needed to prevent self-harm, suicide, or homicide risks.</td>
<td>The client may exhibit high risk or impulsive behaviors that could pose a risk of harm to self/others. They may experience altered thought processes with poor insight and judgment.</td>
</tr>
<tr>
<td></td>
<td>Ensure consistency of behavioral expectations among all staff on the unit by including expectations in the nursing care plan.</td>
<td>Consistent expectations help prevent manipulative behaviors and pushing of limits.</td>
</tr>
<tr>
<td>Health Teaching</td>
<td>Create, adapt, and deliver health teaching to clients, including self-care, self-awareness activities, and milieu group therapy topics. See “Patient Education” topics for bipolar disorder in the box following these tables.</td>
<td>Nurses encourage resilience by promoting adaptive coping strategies.</td>
</tr>
<tr>
<td>Pharmacological, Biological, and Integrative Therapies</td>
<td>Deliver patient education about mood stabilizers and other medications with expected time frames for improvement.</td>
<td>The client’s understanding of their medications and potential side effects can increase medication adherence.</td>
</tr>
<tr>
<td></td>
<td>Open all medications in front of the client.</td>
<td>Opening all medications in front of the client may decrease paranoia.</td>
</tr>
<tr>
<td></td>
<td>Observe for signs of medication toxicity, such as lithium.</td>
<td>There is a small margin of safety between therapeutic and toxic doses of lithium.</td>
</tr>
</tbody>
</table>
Milieu Therapy

Manage the milieu by reducing environmental stimuli and excess noise. The client may require a private room.

Provide structured 1:1 activities with the nurse or other staff. Avoid competitive activities or games.

Encourage frequent rest periods and “down time.”

Promote physical exercise to redirect aggressive behavior.

During acute mania, use prescribed medications, seclusion, or restraint to minimize physical harm.

Store valuables in the hospital safe until safe judgment returns.

Encourage participation in group therapy after acute manic episode has resolved addressing social skills, personal grooming, mindfulness, and stress management.

Use a firm and calm approach with short and concise statements. For example, “John, come with me. Eat this sandwich.”

Be consistent in approach and expectations.

Identify expectations in simple, concrete terms with consequences. For example, “John, do not yell at or hit Peter. If you cannot control your behaviors, you will be escorted to the seclusion room to prevent harm to yourself and others.”

Listen to and act on legitimate complaints.

Redirect energy into appropriate and constructive channels.

Set limits with personal boundaries.

See additional “Communication Tips” in the box below.

Reducing stimuli may prevent escalation of anxiety and agitation.

Structured activities provide security and focus. However, avoid group and/or competitive activities because they may be too stimulating and can cause escalation of anxiety and agitation.

Resting can prevent exhaustion that can result from constant physical activity.

Physical exercise can decrease tension and provide focus.

The nurse’s priority is to protect the patient and others from harm.

Storing valued items protects the patient from giving away money and possessions.

Group therapy can encourage effective coping skills.

Structure and control can improve feelings of security for a client who is feeling out of control.

Consistent limits and expectations minimize the potential for the client’s manipulation of staff and provide feelings of security.

Clear expectations help the patient experience outside controls and understand reasons for medication, seclusion, or restraints if they are not able to control their behaviors.

Listening to legitimate complaints can reduce underlying feelings of helplessness and can minimize acting-out behaviors.
Distraction is an effective tool with clients experiencing mania.

Clients may be impulsive and hypervocal and interrupt, blame, ridicule, or manipulate others.

Table 8.4d Nursing Interventions to Promote Physiological Integrity

<table>
<thead>
<tr>
<th>Problem/ Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nutrition</strong></td>
<td></td>
</tr>
<tr>
<td>• Monitor intake, output, and vital signs.</td>
<td>Ensure adequate intake and minimize development of dehydration.</td>
</tr>
<tr>
<td>• Offer frequent, high-calorie, high-protein snacks, drinks, and finger foods.</td>
<td>“Finger foods” allow for “eating on the run.” The client experiencing mania is unaware of bodily needs and is easily distracted.</td>
</tr>
<tr>
<td>• Frequently remind the client to eat.</td>
<td></td>
</tr>
<tr>
<td>• Monitor laboratory results.</td>
<td></td>
</tr>
</tbody>
</table>

| **Sleep**             |           |
| • Encourage frequent rest periods during the day and adequate sleep during manic episodes. | Lack of sleep can lead to exhaustion and increased mania. Relaxation techniques induce sleep. Encouraging bedtime routines and decreasing caffeine intake increases the possibility of sleep. | [23] |
| • Keep patient in areas of low stimulation to induce relaxation. |            |
| • Before bedtime, provide warm baths, soothing music, and prescribed medication if needed. Avoid caffeine. | |

| **Elimination (Constipation)** |           |
| • Monitor frequency of bowel movements. | Fluids and fiber stimulate peristalsis and soft stools. The client experiencing acute mania is easily distracted and not aware of bodily needs. Bowel management programs may be needed to avoid fecal impaction. |
| • Encourage fluids and foods high in fiber. | |
| • Encourage the client to go to the bathroom. | |
| • Evaluate the need for a bowel management program with stool | |
softeners and laxatives.

Self-Care Deficits

- Encourage the use of a toothbrush, washcloth, soap, and makeup or shaving supplies.
- Encourage appropriate clothing choices.
- Provide step-by-step reminders for hygiene and dress, such as “Wash the right side of your face and now your left.”

Distractibility and poor concentration are countered through simple, concrete instructions. The client is helped to maintain dignity and avoid potential for ridicule that can lower self-esteem.

Effective Communication Tips for Clients with Bipolar Disorder

- Use a firm and matter-of-fact tone and calm approach (client needs structure).
- Use simple, concise, very short explanations (client has short attention span and difficulty focusing).
- Reinforce verbal limit setting on behaviors with personal boundaries (client is impulsive and distractible with limited insight and inappropriate behaviors towards others).
- Utilize therapeutic communication techniques, such as redirecting, active listening, distraction, clarification, or restating; avoid exploring because client’s thought process is too expansive.
- Avoid the use of jargon, jingles, jokes, proverbs, or cliches (client is already overstimulated).
- Remain neutral with careful choice of words to avoid “power struggles.” (A client experiencing a severe manic episode can be manipulative and lack personal boundaries).
- If a client demonstrates agitation with escalation of manic behavior, review interventions described in the “Crisis and Crisis Intervention” section of the “Stress, Coping, and Crisis Intervention” chapter. Additional de-escalation techniques to maintain safety are described in the “Workplace Violence” section of the “Trauma, Abuse, and Violence” chapter.

Patient Education: Bipolar Disorder

Living with bipolar disorder can be challenging, but there are ways to control symptoms and enable oneself, a client, a friend, or a loved one to live a healthy life. The client may be resistant to teaching during the acute phase of a manic episode, so it is beneficial to wait until manic symptoms begin to resolve. Patient education regarding bipolar disorder includes the following guidelines:

- Get treatment and stay committed to it. Recovery from a manic episode takes time and it’s not easy, but treatment is the best way to start feeling better.
- Keep medical and therapy appointments and talk with the provider about treatment options.
- Take all medicines as directed.
- Maintain a structure for daily activities; keep a routine for eating, getting enough sleep, and exercising.
- Learn to recognize mood swings and warning signs for manic episodes such as decreased need for sleep.
• Ask for help when experiencing barriers or challenges for treatment. Social support helps coping.
• Be patient; improvement takes time.
• Avoid using alcohol and illicit drugs.
• Encourage participation in cognitive behavioral therapy (CBT) or dialectical behavioral therapy (DBT).
• Use stress management, relaxation techniques, and coping strategies to minimize anxiety.
• Participate in support groups such as those sponsored by the National Alliance on Mental Illness (NAMI) and the Depression and Bipolar Support Alliance (DBSA).

Implementing Seclusion or Restraints

Controlling escalating agitation during the acute phase of a manic episode may include immediate administration of a prescribed antipsychotic and benzodiazepine. A combination of haloperidol (Haldol) and lorazepam (Ativan) that can be injected for rapid onset of action is commonly used. The nurse must monitor for respiratory depression, hypotension, and oversedation after administering this type of medication.

De-escalation techniques should be attempted at early signs of escalating agitation to avoid the need for seclusion or restraints. However, if a client is escalating out of control to a point where they pose an immediate risk of injury to themselves or others, the use of a seclusion room or restraints may become necessary to maintain a safe environment. Most state laws prevent the use of unnecessary restraint or seclusion, so their use is associated with complex ethical, legal, and therapeutic issues.

Agency policy must be closely followed when implementing seclusion or restraints. Documentation is required that indicates the need for seclusion and/or restraint:

• There is a clear substantial risk of harm to self or others.
• The client is unable to control their actions.
• Other interventions have not been effective (e.g., reducing stimuli, providing distraction, setting limits, verbally de-escalating with therapeutic techniques, or offering PRN medications).

Each agency establishes a proper reporting procedure through the chain of command. For example, seclusion and restraint are only permitted with a written order from an authorized provider (e.g., physician, nurse practitioner, or physician assistant) and rewritten every 24 hours or more frequently according to hospital policy and state regulations. The order must include the type of restraint (e.g., physical or chemical) to be used. In an emergency, the charge nurse may place a client in seclusion or restraints and obtain a written order within a specified period of time (typically 15-30 minutes).

Established agency protocols specify associated nursing responsibilities to maintain client safety while in seclusion or restraints, such as the following:

• 1:1 supervision or visual monitoring
• How often to offer the client food and fluids (e.g., every 30-60 minutes)
• How often the client can use the restroom (e.g., every 1-2 hours)
• How often to measure vital signs (e.g., every 1-2 hours)

Read more details about the legal implications of seclusion and restraints in the "Legal and Ethical Considerations in Mental Health Care" chapter.

Evaluation

Evaluation occurs continuously throughout the treatment of bipolar disorders. The registered nurse individualizes assessments based on the established goals and SMART outcomes for each client. The effectiveness of nursing and collaborative interventions is evaluated and revised as needed. Questions used to guide the evaluation process include the following:

• Is the client medically stable with nutritional intake, sleep patterns, labs, or activity levels?
• Is the client engaging in own self-care measures?
• Is the client safe with no self-harm behaviors, statements, gestures, or threats of harm towards others?
• Is the client engaging appropriately in unit-based activities and the therapeutic milieu?
• Is the client able to maintain appropriate personal boundaries with others?
• Is the client able to engage appropriately in verbal conversations and interactions with others?
• Is the client able to demonstrate insight into own illness?
• Is the client tolerating prescriptive medications at therapeutic serum levels and without key side effects?
• Is the client at or near baseline optimal functioning without manic symptoms?
• Is the client able to participate in their own plan of care including discharge planning?

2. "Cat_and_lion_in_mirror_illustration.svg" by Arlo Barnes is licensed under CC BY 3.0


