

Nursing in different stages of a bipolar manic episode: Coping with dual loyalty and staying connected to outpatients and caregivers is easier when anticipated by having a good connection with both and making relapse prevention plans, a qualitative study.

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## INTRODUCTION

Bipolar disorder is a major mental illness with a life time prevalence of 1.3 % in the Netherlands (De Graaf, Ten Have, Van Gool, & Van Dorsselaer, 2011). It follows a pattern of recurrent manic, hypomanic, depressed, or mixed, episodes (Kupka & Regeer, 2007).

Euthymia is the in-between episode when mania and depression are absent. In euthymic and depressive episodes patients mostly admit the fact of having a disease. During the development of a (hypo-) manic episodes patients often deny having a bipolar disorder and may not recognize manic prodromes (Goossens, Kupka, Beentjes, & Van Achterberg, 2010; Mantere, Suominen, Valtonen, Arvilommi, & Isometsa, 2008). Manic behavior is having a high potential for painful consequences (American Psychiatric Association, 2000), and can therefore be a heavy burden to caregivers (Beentjes, Goossens, & Poslawsky, 2012). Because of experiencing burden in earlier episodes, caregivers develop a watchful attitude to changing moods (Tranvåg & Kristoffersen, 2008).

When caregivers recognize manic prodromes it is possible their relative denies their behavior indicates a (hypo-) manic episode. Worried about a possible manic recurrence and expected quarrels, caregivers often consult a nurse. Nurses, treating patients with bipolar disorder in an outpatient clinic, have to deal with these situations. Caregivers and patients might have different opinions when caregivers consult the nurse about recognizing manic prodromes and in the episode that follows. The caregiver desire is to stop or prevent the consequences of mania and the patient might deny their behavior indicates a manic episode.

Existing guidelines describe the treatment of (hypo-) mania is based primarily on medication (Nolen et al., 2008). Guidelines do not describe how nurses should intervene to patients and their caregivers in the episode that follows after the consult of the caregiver. Review of literature on caregiver burden in the patients' (hypo-) manic episode did not find descriptions of nursing interventions responding to caregiver burden when the patients' mood is changing towards mania (Beentjes et al., 2012).

### **Problem statement**

Unknown is what nurses experience when they are confronted with a difference in opinions between caregivers and patients when the patients' mood is changing towards mania. This episode starts at the moment when caregivers consult nurses because of recognizing prodromes of a manic episode in the patients' condition. Unknown is how nurses intervene to caregivers and patients in the before described situations.

**Aim**

The purpose of this study is to describe the nurses' experience, and interventions to caregivers and patients when the patients' mood is changing towards mania. Nurses can use this description to reflect on their own way of responding to the before mentioned situations.

**Research questions**

The primary research questions of this study is:

- What do nurses experience when they are confronted with different opinions of caregivers and patients when the patients' mood is changing towards mania?

The secondary research questions of this study is:

- Which interventions do nurses use when responding to the different opinions of caregivers and patients when the patients' mood is changing towards mania.

**METHOD**

The study followed a qualitative approach. Participating nurses were asked to reflect on their concerns and their interventions to caregivers and patients when they are consulted by caregivers because of recognized prodromes of a manic episode in the patients' condition and in the episode that follows. For this purpose open individual interviews were held.

**Sampling**

Included were registered nurses working more than two years in an outpatient clinic treating patients with bipolar disorders on a daily base. Nurses working less than two years could have too little experience with treating outpatients in a manic episode. The sampling method in this study was purposive. Participants were recruited from the nurses who regularly visit the clinical scientific meetings of the Dutch association for bipolar disorder. These nurses have special interest in treatment of patients with bipolar disorder and they were likely to fit the inclusion criteria.

**Interviews**

The first author interviewed the participants after signing the informed consent. The open interview took place at the office of the participant. In an attempt to set aside his personal experience, the researcher described his own experience so that the focus could be directed to the participants. With this personal experience, and discussions between the first two authors an aide memoires was developed. At the end the interview the aide-memoires was checked. After each interview the aide memoires was revised.

The interview started with the introduction of the situation that a caregiver is consulting the nurse about observed manic prodromes of the patient. The first question was: "did you experience such situations and could you tell me more about this".

At first, five interviews were planned. When necessary new interviews were arranged. The seventh interview produced only illustrations of before reported issues. Two new interviews confirmed data saturation. The interviews were tape-recorded.

### **Data analysis**

The analytic process of the study followed the approach as described by Creswell (2007).

The gathered data contained verbatim transcriptions, field notes, and short reports of the interviews. After reading the transcriptions thoroughly a list was developed with significant statements. These significant statements were coded. The identical or similar codes were grouped into meaning units. The next analytic step was to develop descriptions of what happened (textural description) between the participants, the patients and the caregivers and how participants experienced (structural description) the given situations. Finally the essence of the experience was developed. The first two authors thoroughly discussed the steps that were made in the analytic process.

To enlarge the trustworthiness of the data the participants could check the results of the analysis. Six out of the nine responded and validated the results.

## **RESULTS**

The number of years that the participants worked with outpatients with bipolar disorders varied from 3 to 19. The percentages of patients with bipolar disorder in the total caseload of the participants varied from 40% to 100%. Figures on years of experience and the caseload of the participants are presented in Table 1.

All the participants are often consulted by caregivers because of signs of a manic episode in the patient. From the data three themes emerged. At first, the theme 'dual loyalty' characterizes the way participants experience conflicting interests of patients and caregivers. The second theme is 'staying connected'. The participants apply themselves to stay in contact with the patient and the caregiver. 'Anticipating' is the last theme. Participants intervene in euthymic episode to be prepared to the difficulties in the first two themes.

### **Dual Loyalty**

Participants experience dual loyalty when taking the caregiver seriously is potentially affecting their confidential relation to the patient.

When participants are consulted, they feel caregivers can put a lot of pressure on them. E.g. when a caregiver urge the patient must be hospitalized. Participants can imagine the concern or anxiety that caregivers can have when they observe prodromes of mania. It can remind them of damage caused by an earlier episode. Taking the caregiver seriously can possibly mean they risk their relationship with the patient. Their first concern is to preserve the patients' privacy and autonomy. They want patients to manage their own lives and learn them to manage their own disease. The patients' privacy is in stake when caregivers consult participants behind the patients' back.

*I don't like partners talking about the patient. I think everyone must be able to direct his own life as much as possible, even when hypomanic. For me that's number one. The patient is always responsible for himself. That has got to do with my own values. In relations you are equals.*

*(Participant 6)*

Participants assess whether the patients' behavior is part of an episode or it is a normal reaction to a normal conflict. A quarrel between the patient and caregiver could start with an over-concerned attitude of the caregiver. Caregivers often proclaim the patient is manic when he laughs aloud or when he is angry. Caregivers can feel they are doing well by keeping control of the situation, e.g. taking care of the patients' medication. Participants can feel uncomfortable when they see patients are kept in the underdog position and when patients are unjustly marked as being manic. Participants have in mind to protect patients against the caregivers' critical attitude.

*I got it clear there was a quarrel going on. The woman was angry because her husband hadn't taken her seriously. In reaction she teased and provoked him. The caregiver said: "She is getting manic again, say goodbye to the holiday". But she was still sleeping well, and that's her first signal. (Participant 1)*

When a manic episode is going on the dual loyalty tends to turn. Participants can feel more sympathy to caregivers for they can suffer enormously from mania. Participants think that mania is never in the interest of patients. During a manic episode participants keep loyal to the patient they know from the euthymic episode. This is the episode in which protection was asked.

*Certainly when he searches quarrels all day long, you see relatives are suffering. At that moment it might be the patients' own interest, but when he came into care he asked me something else. That was: "When I am not well, I want you to act firmly." (Participant 3)*

When the patients' manic behavior is dangerous the dual loyalty turn totally. Participants fully agree with caregivers the consequences of mania should be stopped. Participants can sympathize with caregivers who feel it can last long before the consequences of the patients'

behavior are dangerous enough to justify a compulsory admission. At the moment compulsory actions are necessary participants do not worry anymore about their confidential relationship with the patient.

*At that moment your professional relation with the patient is of secondary interest. You want to get the crisis under control as soon as possible. (Participant 8)*

### **Staying connected**

When the caregiver consults participants, the first question to the caregivers is whether they talked it over with the patient. Participants want to open the communication with the patient because patients can get suspicious. Not being open means participants could lose their trustworthiness to the patient. Even so they need to be able to motivate why they call the patient.

*To a caregiver: "When you ask me not to say that you called me; where do I stand? Should I call the patient out of the blue saying: Well hello, this is ... (name of the participant), how are you today? That's a silly entrance, don't you think." (Participant 2)*

When participants assess problems are caused by an over-concerned attitude of the caregiver, they strive to keep in contact with the patient and the caregiver. Participants need them both to learn to resolve their quarrels. Participants will recognize their mutual suffering, explain their needs and intensions, ask them both to understand the others position, and to meet the others intensions.

*Well what can I say to make clear that I am present for both parties? I mostly try to look on both sides. I ask the caregiver what they need, and the patient what they can do to lessen the partners' worries. (Participant 3)*

When patients are in hypomania the participants try to intervene in the same way: taking them both seriously. The urge to stay in contact with the patients is bigger. Because of their irritability patients are easily offended and could step out of contact. Participants don't want that patients think a front is formed against them. This could happen when participants rely more on the caregivers' opinion because patients might have too little insight in their own condition. To prevent the patient steps out of contact the participants' try not to judge on the patients. They are transparent about what they think and will do, and they give understandable feedback to the patient. Participants strive to reach the point that the patient is willing to admit their behavior is manic.

*You're alert; otherwise you fight a boxing match. In the worst case people step out of contact. You notice you choose your words more careful. (Participant 9)*

*I am getting diplomatic, so to speak. I will ask the patient to explain what they exactly mean. I tell them what I see, very specific, and also saying that I see their partner is suffering too.*

*(Participant 8)*

When the patient is no longer responsive or when the contact with the patients is lost, the participants stay connected to the caregiver. Participants monitor the patients' condition via the caregivers. Sometimes this contact is behind the patients' back, ignoring privacy regulations and the patients' consent. At the same time participants take time to listen to the caregivers and estimate the extent of the caregivers' burden.

*In some cases I didn't ask permission for contacting the caregiver because I expected the patient would not allow me. Sometimes you fiddle with privacy regulations. I think reducing the risks and danger is of a bigger interest to the patient. (Participant 7)*

When the mania is in remission participants get into contact with the patient again. The connection with the patient is easily restored. Often patients are relieved the mania stopped. After the episode it is very rare that patients don't approve the nurses' interventions without the consent of manic patients.

*Well yes, she was very angry because of the admission. I will see her next week. I will explain in what condition she was, and the reason why we took action. I am not afraid she stays angry. I never experienced it. (Participant 6)*

During the interview a number of participants realized that, inadvertently, the contact with the caregiver easily dilutes after the episode. They considered inviting caregivers more frequently.

*When she recovered the contact with her son stopped. I should have contact with the patients' children earlier and more frequently not only when it is going wrong. (Participant 5)*

### **Anticipating**

During the euthymic episodes participants anticipate the before described difficulties. Knowing the patient and caregiver and having a solid connection to them both makes the before described situation more easy. Its' easier to assess whether the mania is real or the caregiver is over-concerned and the patient and caregiver are more compliant to the interventions in the episode that follows. Therefor some of the participants have a policy to invite the caregiver right from the start of the treatment. Participants feel that going through a tough episode together empowers the relation with the patient and the caregiver. All participants make agreements with patients and caregivers that both can contact participants when they observe early signs of a manic episode. Participants require that caregivers inform the patients before they contact the participant.

*When you see symptoms don't hesitate to call me, only than I can take action. And your daughter is always welcome to make an appointment with me more early. (Participant 4)*

Most participants make relapse prevention plans with patients and caregivers. In a very concrete manner this plan describes the patients' behavior during the course of episodes and prescribe what to do to keep in control. The agreements mentioned before are also written down in relapse prevention plans. During episodes, participants use relapse prevention plans to compare the patients behavior to what is written down. Giving feedback can be more objective. With the relapse prevention plan in hand participants can motivate and justify the necessary compulsory actions, because they are written down and the patient in euthymia agreed on them. A number of participants evaluated the episode. They explained why they acted compulsory. Relations are restored and even become more intense. The relapse prevention plan was revised together with patients and caregivers. They learned about what triggered the episode. When the contact with caregivers dilutes they could not participate in the evaluation.

*(In a manic phase:) What can we do? An action is helpful. You have written it out in a stable phase. It says what can occur and what to do. So we walk through the plan and look for what we agreed on. .... After the episode we discussed what went good and wrong. What should we do different next time? We revised the action plan. (Participant 2)*

## DISCUSSION

Nurses working with outpatients with bipolar disorder are confronted with caregivers who consult nurses because of prodromes of mania in the patient. Three themes determine the nurses' experience and interventions from that moment and the time that follows: dual loyalty, the need to stay connected to patients and caregivers, and the way nurses anticipate this episode. In euthymia nurses anticipate the difficulties that might occur later on in the episode. Solid connections to patients and caregivers and making relapse prevention plans with them, make staying connected to the patients and caregiver and coping with dual loyalty easier. Dual loyalty is what nurses feel when caregivers consult them. On the one hand nurses want to take the caregivers serious and on the other hand they need to preserve the patients' privacy and autonomy. Nurses want to stay connected openly to the patient to prevent they are offended by contacts behind their back. Dual loyalty also exists when nurses want to protect the patient against the caregivers' over-concerned attitude. Nurses stay connected by taking them both serious and by recognizing their mutual suffering.

In (hypo-) manic episodes dual loyalty tend to turn. Nurses see caregivers can suffer from mania. Nurses want to stay connected to patients as long as possible, in an open and



transparent attitude to prevent patients step out of contact. Patients can easily be irritated and are less reliable because of their denial. Nurses need to stay connected with caregivers to monitor the patients' condition via the caregiver. When mania is getting dangerous the confidential relation with the patient is of lesser importance than getting control over the crisis. Nurses act without the patients' consent when necessary.

After the episode the relapse prevention plan is revised. When mania is in remission the connection to patients is easily restored. It is very rare that patients don't approve the compulsory actions of the nurse.

The first author is a nurse working with outpatients with bipolar disorder. In spite of his bracketing, he might be biased by his own propositions because of his content involvement. This might be a limitation of this study. However, respondents are experienced mental health nurses and acknowledged the results in the member check.

The nurses' experience matches the definition of the phenomenon dual loyalty. Baldwin-Ragaven et al. (2002) defines this phenomenon as clinical role conflict between professional duties to a patient and obligations to the interests of a third party. Nurses apply themselves to stay connected by taking them both seriously. Nurses prefer an open, transparent, and non-judging attitude. During the process the nurse is present, empathic, and, if necessary, decisive and setting clear boundaries. This attitude matches many of the constructs of a quality therapeutic relationship (Dziopa & Ahern, 2009). Being present and having attention for the caregivers' burden in times of mania could be a supportive intervention to caregivers. This can empower a solid relationship with the caregiver.

Patients have the need for 'timely indication of early warning signs' (Goossens, Knoppert-van der Klein, Kroon, & Van Achterberg, 2007). Caregivers might have the same need. Nurses match this need by making agreements on timely consulting nurses. These agreements are written down in relapse prevention plans. Making relapse prevention plan is common practice in the Netherlands (Goossens, Beentjes, De Leeuw, Knoppert-van der Klein, & Van Achterberg, 2008) and it can reduce the number of manic episodes (Perry, Tarrier, Morriss, McCarthy, & Limb, 1999). The caregivers' contribution to preventing manic relapses is not reported. Evaluating the relapse prevention plan after a manic episode enables learning from experiences. Caregivers should be involved in this evaluation. It can make relations between nurses, patients, and caregivers more solid.

Continuity of professional relationships is a central theme all the way through the results. Bipolar disorder is characterized by its chronic course (Kupka & Regeer, 2007) and therefore patients need long-term professional relationships. Because of health costs reduction in the Netherlands long-term care relations are under discussion. This study illustrates the benefits

of long-term professional relationships with patients with bipolar disorder and their caregivers. However, involving caregivers into this long-term treatment is not yet common practice.

### **Conclusion**

Nurses experience dual loyalty in the episode that follows the moment that caregivers consult nurses because of prodromes of mania in the patient. Taking caregivers serious can affect their confidential relationship with patients. Nurses intervene by staying connected to both as long as possible. In fear of the patient's irritability nurses are open and transparent to the patient. When patients step out of contact nurses monitor the patients' condition indirectly, sometimes ignoring privacy regulations. Afterwards patients accepted the nurses' firm interventions even those without the consent of patients in mania. Nurses experience interventions are easier when anticipated to the episode by having solid relations to patients and caregivers, and making relapse prevention plans.

### **Recommendations**

- Involve caregivers into the treatment of patients with bipolar disorders, right from the start.
- Make relapse prevention plans together with the patient and the caregiver and evaluate them after each episode.

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**Table 1.** Experience and caseload topics of the participants.

Participants' number	1	2	3	4	5	6	7	8	9
Number of years being a mental health nurse	42	11	26	25	25	31	18	40	34
Number of years working with outpatients with bipolar disorder	10	3	19	8	12	11	3	14	17
Percentage of patients with bipolar disorder in the participants' caseload (%)	100	80	95	100	40	100	100	75	100
Only working with elderly patients (>65)	-	-	-	-	x	-	-	-	-

## DUTCH SUMMARY

**Titel:** Het verplegen van opvolgende fases van een bipolaire manische episode: Omgaan met dubbel loyaliteit en in contact blijven gaat gemakkelijker als er een goed contact met de ambulante patiënt en zijn naastbetrokken is en als er een signaleringsplan is. **Inleiding:** De bipolaire stoornis kent een patroon van verschillende stemmingsepisodes. Acute manie veroorzaakt duidelijke beperkingen in sociaal- en werk functioneren. Het kan behoorlijk ontwrichtend zijn voor families en naastbetrokkenen. Regelmatig consulteren naastbetrokkenen verpleegkundigen als zij prodromen van een manische episode zien bij de patiënt. **Doelstelling:** Verpleegkundigen kunnen op hun eigen praktijk reflecteren na het lezen van dit artikel. **Onderzoeksvraag:** Wat ervaren verpleegkundigen en hoe gaan ze om met verschillende belangen van patiënten en naastbetrokken als de stemming verandert naar een manie? **Methoden:** Deze studie volgt een kwalitatief ontwerp. **Resultaten:** Verpleegkundigen ervaren dubbele loyaliteit. Het serieus nemen van naastbetrokkenen kan effect hebben op hun vertrouwelijke relatie met de patiënt. Om te voorkomen dat de patiënt uit het contact stapt leggen verpleegkundigen zich toe om in contact te blijven door een open en transparante houding. Verpleegkundigen blijven ook in contact met naastbetrokkenen, als dat nodig is negeren ze privacyreglementen. Na een episode is de relatie met de patiënt makkelijk hersteld.

**Conclusie:** Omgaan met dubbele loyaliteit en het in contact blijven met de patiënt en naaste, als de stemming verandert naar een manie, is gemakkelijker als er een goede relatie met de patiënt en naaste is en er een signaleringsplan gemaakt is.

**Aanbevelingen:** Betrek naastbetrokkenen bij de behandeling van patiënt met een bipolaire stoornis. Maak en evalueer een signaleringsplan met patiënt en naastbetrokkene.

**Trefwoorden:** Bipolaire stoornis, Dubbele Loyaliteit, Manische episodes, Naastbetrokkenen.

**ENGLISH ABSTRACT**

**Title:** Nursing different stages of a bipolar manic episode: Coping with dual loyalty and staying connected to outpatients and caregivers is easier when anticipated by having a good connection and making relapse prevention plans, a qualitative study.

**Background:** Bipolar disorder follows a pattern of different recurrent mood episodes. Acute mania causes marked impairment in social or occupational functioning and mania can be quite disruptive to families and caregivers. Caregivers often consult nurses because of recognizing prodromes of a manic episode in the patients' condition. **Aim:** Nurses can reflect on their own practice when reading this report. **Research question:** What do nurses experience towards different opinions of caregivers and patients when the patients' mood is changing towards mania and how do they respond to it? **Method:** This study follows a qualitative design. **Results:** Nurses experience dual loyalty. Taking caregivers serious can affect their confidential relationship with patients. In fear the patient steps out of contact nurses strive to stay connected to the patients in an open and transparent manner. Nurses also stay connected to caregivers. When necessary ignoring privacy regulations. The connection with the patient after the manic episode is easily restored.

**Conclusion:** Coping with dual loyalty and staying connected to patients and caregivers, during stages of a manic episode, is easier when anticipated by having a good connection and making relapse prevention plans.

**Recommendations:** Involve caregivers into the treatment. Make and evaluate relapse prevention plans with patients and caregivers.

**Keywords:** Bipolar disorder, Dual Loyalty, Manic episodes, Caregiver burden.