A 35-year-old man with grandiose ideas and disinhibition

COMMENTARY BY **GORDON JOHNSON** MB BS, FRANZCP, FRCPsych

A university academic is brought in by his wife. He has developed grandiose ideas and a general disinhibition, different from his usual calm demeanour. How should he be assessed and treated?

Case scenario

A 35-year-old university academic reluctantly attended the surgery with his wife who was very concerned about his recent behaviour. She said that following a period of intense stress and overwork, he had become particularly 'revved up' over the last few weeks and was full of grandiose ideas and a general disinhibition. This was quite different from his usual calm and controlled demeanour and she felt she could not 'connect' with him. He strongly denied any problem and did not appear to have psychotic symptoms at the consultation, but had a history of a brief, treated depression in his early 20s. How should this be managed?

Commentary

Assessment

The first priority is to make an adequate assessment. The history presented by the patient's wife suggests a mood disorder with a current episode of mania. Assessment requires the patient's co-operation.

An initial step is to see the patient on his own and allow him time to present his side of the story. Let him talk uninterrupted, at least for the first few minutes. This will demonstrate willingness to listen and will help to establish a rapport with the patient. It may also yield observations about his behaviour and mental state, which will guide more direct questions.

The patient's general demeanour may be expansive and his behaviour over-familiar or disinhibited. His speech may be accelerated and loud. His mood may be one of irritability, which is likely given that he has agreed to see you only reluctantly. Mood lability may also be evident with brief jollity or anger. He may be restless and fidgety and find it difficult to remain seated.

Where appropriate, questions should be directed towards:

- ascertaining greater details of the circumstances leading up to the change in behaviour reported by his wife
- exploring his past history of depression
- obtaining a medical and drug and alcohol history to exclude mania secondary to drugs or medical illness.

The presence of a family history of mood disorder is also relevant because heritability, particularly in bipolar disorder, is an important causal factor.

Given the patient's co-operation, exploring the reports of grandiose ideas is important to establish whether there is evi-

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dence of psychosis. A firmly held conviction that he has a special mission or special powers, or that he has been singled out as a special person in one way or another, are characteristic of grandiose delusions in mania.

Management of mania

The major risks associated with mania result from lack of insight and impaired judgement leading to reckless and disinhibited behaviour, which may have damaging personal, social or financial consequences for the patient and family. Early intervention with appropriate pharmacological management is required to minimise these risks.

Where and by whom should he be treated?

The first question is where and by whom should the treatment be carried out. Psychiatric referral should be obtained as soon as possible. As this is the first episode of mania, hospitalisation is desirable for an appropriate assessment and initiation of treatment. Where the patient refuses treatment, hospitalisation under the Mental Health Act may be required.

Which drug should be used?

The treatments of choice are mood stabilising agents, such as lithium (Lithicarb, Quilonum SR), or the anticonvulsant sodium valproate (Epilim, Valpro). Both drugs have established effectiveness in the treatment of mania.

Lithium has a narrow therapeutic index with plasma levels of 0.8 to 1.2 mmol/L required for therapeutic efficacy in most patients with mania. There is a lag of onset of five to 10 days before therapeutic effects become evident. Depending on the severity of mania, adjunctive antipsychotics and/or benzodiazepines may be required in the early stages of treatment to control manic behaviour.

Sodium valproate has an advantage in that its dosage can be escalated rapidly, which may lead to a more rapid onset of action with a lesser requirement for adjunctive agents. The plasma levels recommended are similar to those advised in the treatment of epilepsy.

How long should treatment last?

The usual duration of treatment required to obtain resolution of mania is two to four weeks. Maintenance treatment with a mood stabiliser is recommended. Clinical trials have established lithium as the 'drug of choice' as a prophylactic treatment in bipolar disorder.

An episode of bipolar disorder with the attendant hospitalisation and treatment, particularly if it is involuntary, is a devastating experience for the patient, and appropriate psychotherapeutic follow up is important in the recovery process.

Outlook for the patient

For this patient, the illness may have a significant impact on his career, particularly if there is an ensuing depressive phase with more prolonged disability. On the other hand, bipolar disorder is not incompatible with a full and successful life and may confer some advantages in terms of creativity, a fact often cited in the careers of famous artists with a known history of bipolar disorder. MT

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