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Case report

BIPOLAR DISORDER PRESENTING AS STALKING - A case report

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SUMMARY

Background: *Stalking behaviour may find its roots in an individual's psychological development and culture-related factors that facilitate it. Psychiatric disorders may underlie some stalking cases, but no reports exist of the relationship of actual psychiatric status with the expression of stalking behaviour.*

Case Report: *A 22-year-old adoptive woman perpetrated stalking towards her gynaecologist, who took legal action to protect herself. She was admitted to a general hospital psychiatric department and diagnosed with bipolar disorder-I, manic phase, and personality disorder, not otherwise specified. She was prescribed lithium and valproate combination and followed-up as an outpatient. She underwent cognitive-behavioural therapy incorporating Bowlby's concepts. Stalking behaviour did not reemerge.*

Conclusion: *Exacerbations of psychiatric episodes may trigger stalking behaviour. Drug treatment may prevent its clinical expression, but underlying ideation and affect may need long-term psychotherapy focusing on attachment.*

Key words: *stalking, bipolar disorder - object attachment - lithium*

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INTRODUCTION

Stalking is "the wilful, malicious, and repeated following or harassing of another person that threatens his or her safety" (Meloy & Gothart 1995). A crime in Italy since 2009, it is increasingly gaining space in the media. Its relation with specific psychopathology is not clear, but may be related somehow to subtyping. Mullen et al. (1999) identified five different stalking patterns in adults, i.e., rejected, intimacy-seeking, incompetent, resentful, and predatory, relating them with different disorders such as personality disorders, delusional disorder, erotomania and paraphilias.

Bipolar disorder, although commonly encountered in the everyday practice of people dealing with stalkers (Mullen et al. 2001), has been reported only once in the peer-reviewed literature and with little detail in Mullen and Pathé's (1994b) case series. However, its impact on stalking behaviour is probably underestimated, as psychiatric trainees have rarely taken the view of considering the behaviour of people with mania or other severe psychiatric disorders as harassment (Morgan & Porter 1999).

We here report a case of a woman stalking another woman; the perpetrator was affected by bipolar disorder comorbid with personality disorder, not otherwise specified. She manifested stalking behaviour during her mixed mania phase; the stalking subsided as soon as she was able to control her mood symptoms through lithium.

CASE REPORT

We hospitalised at an acute psychiatric care unit a 23-year-old Romanian-born woman, adopted at three years by an Italian couple, due to exacerbation of manic symptoms.

She never met her biological parents and grew in an orphanage until adoption. She recalls little of that period, but her adoptive parents reported she had multiple scratch and burn injuries on her forearms. Until age six, she reported enuresis that resolved spontaneously thereafter. During infancy, she suffered recurrent febrile episodes and has been successfully treated for tuberculosis. She developed normally thereafter. During adolescence, she suffered from bronchial asthma and is currently affected by bouts of unspecified "colitis" and migraine attacks. Currently, she has a job and is about to graduate in political sciences. She drinks about five cups of coffee daily, and denies the use of alcohol, nicotine or other drugs.

Eleven years ago, she lost her adoptive grandfather. This prompted her to start asking repeatedly and obsessively her schoolteacher to adopt her, because she reminded her of her natural mother (whom she never met). Following this episode she received psychological

support for about 18 months, but received no diagnosis. At age 16, she had a romantic relationship with a boy from her group of peers. The relationship broke-down after five years; during that period, they had intercourse twice, with dyspareunia and low libido. After the end of her romantic relationship, she showed menstrual irregularities and visited a 40-year-old female gynaecologist with her mother. During that visit, the patient underwent ultrasonography only, because she "was ashamed of taking-off her clothes". She later called the same gynaecologist and asked her for another visit to discuss her problems with sexuality, but the latter refused with no explanation. Following this, the patient started calling the doctor by her mobile and messaging her for about two months. Thereafter, the patient moved to another place for four months, for professional reasons. During this period, she met another male partner and manifested again the same sexual dysfunction, hence she contacted her gynaecologist again. This time the doctor agreed to see the patient. In January 2009 they scheduled four visits, three at the doctor's workplace and one in the doctor's home, where the latter was living with her husband, an attorney. All four times, according to the patient, the doctor engaged in masturbatory acts with the patient. At the end of January 2009, the doctor terminated their relationship abruptly. The patient responded vexing the gynaecologist with an average of 30 daily text messages to her mobile; this led to the doctor suing the patient for stalking. The patient recalled being irritable during this time, and with frequent crying spells and insomnia, but also high energy; however, she was very successful at work.

After having failed to obtain a positive response from the gynaecologist, she inserted the latter's telephone number in a partner exchange list on the web, causing considerable distress to her doctor. This led to the issuing of a protection (intervention) order in March 2009, so the patient received warning to avoid approaching the doctor. Her lawyer referred her to a psychiatrist, who scheduled four visits with the patient in a month, which the patient did not miss. She complained of early and middle insomnia, with reduced total sleep duration (about three hours per day). She overtly violated the restrictive order in June 2009, and was hospitalised according to her psychiatrist's suggestion in late June 2009.

At intake she was cooperative, her speech was accelerated in the face of reduced facial mimicry; in some instances her smile was fatuous. Her thoughts were racing and focused on her relationship with her gynaecologist; she was doubtful about her gender orientation. Her mood was dysphoric, and free-floating anxiety and angst were apparent. We diagnosed DSM-IV-TR Bipolar Mood Disorder, Mixed Episode, moderate. She scored 21 on the 21-item Hamilton Depression Rating Scale and 21 on the Young Mania Rating Scale.

Routine blood chemistry tests, 1.5 T brain magnetic resonance imaging, and electroencephalogram yielded hyperprolactinaemia (63.33 ng/ml, rising to 118.12 ng/ml one week after treatment with 500 mg/day valproate, 2 mg/day oral risperidone, and 2 mg/day clonazepam) as the only abnormal finding.

On the Millon Clinical Multiaxial Inventory-III (MCMI-III), she scored high on the Dependent Personality Disorder and Narcissistic Personality Disorder scales, in the persistent trait range, and in the trait range on the Paranoid Personality Disorder scale, compatible with acquiescence and submissiveness, and hypervigilant sensitivity. On the MMPI-2, no defined code-type emerged, but she scored high on the Masculinity/femininity scale. Her responses to the Rorschach Inkblot Test were the minimum required and focused on sexual themes involving her gynaecologist. Her prevalent TEMPS-A temperament was hyperthymic.

The patient, despite being able to correctly identify stalking behaviour in others, failed to classify her behaviour as stalking, as shown by her score on the Yanowitz survey (23).

In spite of the possibility of early physical and psychological abuse, she scored in the normal range on the Dissociative Disorders Interview Schedule. On both Empathy and Systemising Quotients she obtained average scores for ability to understand other people's feelings and appropriately responding to them, and for analysing and exploring a system, showing a balanced brain orientation.

A trained psychologist carried-out the Adult Attachment Interview with the patient; two independent raters coded verbatim transcripts. She was classified as F1/Ds3b, i.e., mixed secure attachment on the dismissing side, with a probable harsh childhood, and dismissing, with parental descriptors unsupported rather than contradicted.

She was discharged after 18 days from our psychiatric inpatient unit with the diagnosis of "Bipolar Mood Disorder-type I, current episode, Mixed" and "Personality Disorder, Not Otherwise Specified". At discharge her mood, sleep and speech were normal and her thinking was less focused on her predominant ideas; a mild sense of inner tension was the only residual symptom.

A forensic psychiatrist who was charged by the Court to assess the patient confirmed the diagnosis of bipolar mixed state.

She has been followed-up since July 2009 weekly as an outpatient, treated with valproate 750 mg/die, lithium carbonate 600 mg/die, risperidone 0.25 mg/die, clonazepam, 0.3 mg/die, and cognitive-behavioural psychotherapy with a female therapist. During her psychotherapy sessions, she idealised her therapist, but the latter immediately interpreted her behaviour convincingly, hence the patient ceased her fantasies.

Only one episode of stalking-like behaviour occurred in late August-early September 2009, when the patient admittedly was nonadherent to drug treatment. She is currently euthymic, well-functioning, and her thinking is not focused on her former gynaecologist. She has not fully gained insight into her illness, since she anticipated she will quit medication as soon as the process is over, but stated that she will no longer bother her former gynaecologist. However, she is willing to pursue finding a woman she believes will fit into her idea of her natural mother in order to engage in an emotional, albeit not necessarily sexual, relationship.

She gave free, informed consent for the publication of her case. We omitted or altered some details in this account to protect the patient's identity.

DISCUSSION

We described a patient who presented with stalking behaviour as the first overt manifestation of her manic phase of bipolar disorder. The stalking behaviour subsided when the patient accepted stabilising treatment and recurred during a period of treatment nonadherence.

Our patient belongs to Mullen's et al. (1999) intimacy-seeking subtype. We may infer some degree of reality distortion, interpretable as having a delusional matrix, from her identifying mild stalking as stalking, but failing to recognize it in her own behaviour.

This patient had a diagnosis of comorbid bipolar disorder and personality disorder NOS; the latter is an ill-defined entity, with an impulsive component that may benefit from lithium (Sheard et al. 1976). It could be that the patient's personality prompted stalking behaviour, but it is remarkable that it subsided only when the entire manic episode was set-off.

The results of both Rorschach and MMPI (high score on the Mf scale) were in line with a gender identity problem that may have arisen because of her attachment style. She developed a romantic-like attachment to her doctor similar to the one observed by Pathé et al. (2002) in socially inept stalkers who pose misplaced expectations on their doctors.

The patient's early placement in an orphanage and subsequent late adoption, as well as early caregivers' state of mind about attachment and adoptive mother's attachment style might have influenced her attachment style (Veríssimo & Salvaterra 2006) and affected later stalking behaviour.

It is possible that the traumatic loss related to abandonment and early ineffective fostering, as well as defective working-through of the problem, due to the inadequacy of her adoptive mother, generated in the patient a frustrated need to create a relationship with a reference figure. The need was unmet, partly because a mixed secure-dismissing attachment pattern possibly resulting in motivational system incoordination, expressed as sexualisation of a possible surrogate mother-child relationship, and partly because a psychologically immature adoptive mother preferred not to work through, but rather to deny the issue. The attachment pattern of our patient did not match the predictions of the Meloy model, according to which stalking is expected to be associated with anxious-preoccupied attachment, while psychopathy would be associated with dismissing attachment (Meloy 2003). Our patient was overall secure and somehow dismissing, while psychopathic traits did not emerge from her Millon scores.

Mullen et al. reported that stalking behaviour subsides after improvement of the underlying psychiatric disorder; this is particularly true for bipolar episodes (Mullen et al. 2001). This could involve the molecular underpinnings that link the disorder to non-secure attachment. Lithium is known to potentiate the function of molecules involved with attachment, like oxytocin (You et al. 2001), vasopressin (Watson et al. 2007), and opioid peptides (You et al. 2001). It is possible to attribute some of the action of lithium to the manipulation of the function of these peptides, ensuing in the reorganisation of the activity of the circuitry related to internal working models. This reorganisation could match behavioural improvement.

A neurochemical mechanism has been advanced to explain stalking behaviour that points to an imbalance between serotonergic and noradrenergic transmissions (Meloy & Fisher 2005), but how these diverse brain dysfunction patterns may ensue in eliciting a final common pathway that leads to stalking behaviour is still unknown. However, lithium affects both types of neurotransmission in the brain (Avissar et al. 1988; Scheuch et al. 2010) and it is possible that it reduces stalking behaviour in part through such mechanisms.

Stalking associated with non-compliance with treatment of bipolar disorder has been reported in a man who subsequently complied with treatment to avoid conviction and ceased to present with stalking-associated problems (Meloy 2002); however, the onset of bipolar disorder in this patient, unlike our case, had preceded the onset of stalking by several years. To date, we know of no cases of bipolar disorder presenting as stalking.

CONCLUSION

Our case illustrates that effective pharmacotherapy may prevent actions with possible legal implications related to having a manic phase of bipolar disorder, but the ideation underlying such actions may persist, probably needing other types of treatment than lithium-valproate combination. Adding cognitive psychotherapy has not heretofore abated the patient's at-risk-for-stalking ideation. Such ideation might be the product of the tendency of the adoptive adolescent to idealize excessively his/her natural parents. We must also consider that intimacy-seeking stalkers are particularly

resistant to realizing the judicial implications of their behaviour and they do not give-up their efforts at target, unless authorities issue an involuntary hospitalisation order. Furthermore, our case shows that an accurate assessment of mood dimensions is warranted in cases of unexplained stalking, as it may herald the onset of a psychiatric mood disorder.

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