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THE DEVELOPMENTAL STAGES OF BIPOLAR DISORDER: A CASE REPORT

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SUMMARY

Bipolar disorder is a developing disorder; its early stages are sometimes misdiagnosed as anxiety or depressive disorders. At the same time, these disorders are often in comorbidity with bipolar disorder. This complex symptomatology can lead to misinterpretation and underdiagnosis of bipolar disorders, mainly at the earliest stages. Consequently, one of the most important challenges for clinicians is to recognize the non specific early symptoms with the aid of clinical information, for example a family history of bipolar disorder. Furthermore, it is well-known that comorbid anxiety disorders can lead to a worse prognosis in bipolar patients but it is not exactly clear to what extent. A deeper understanding of the relationship between these comorbidities and their stage of development will hopefully lead to better care of patients with bipolar disorder from a younger age.

Key words: *bipolar disorder – anxiety – OCD – comorbidity - illness developmental trajectory*

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INTRODUCTION

According to previous studies (Angst 2000, Leboyer 2005, Duffy 2010), the high-risk period for the onset of major mood episodes associated with bipolar disorder is adolescence.

On the basis of this evidence, many researchers have stated that non-specific antecedents (Shaw 2005) characterized the earlier phases of bipolar disorder and the heterogeneity of the disorder may influence the illness developmental trajectory (Alda 2004, McGuffin 2010).

Duffy and colleagues (Duffy 2010) speculated that bipolar disorder might proceed in different stages: firstly the patients may complain about non-specific non-mood disorders in childhood (i.e. anxiety), followed by minor mood and adjustment disorders in early adolescence. Finally, they develop major depressive episodes. It is only in late adolescence and adulthood that patients may present with hypomanic or manic episodes.

Furthermore, Gottesman and colleagues (Gottesman 2010) stated that a positive family history is the most robust risk factor that predicts bipolar disorder.

Moreover, it is known that childhood anxiety disorders are associated with an increased risk of major mood disorders later in life and evidence supports a progressive transition through clinical stages (Duffy 2014).

In particular, according to recent research (Lee 2008), bipolar patients with comorbid anxiety disorders report a greater severity of their illness than those without comorbid anxiety disorders. In fact, they are more likely to have an earlier age of onset of illness and a more frequent history of substance abuse. In consideration of the bipolar type, higher prevalence rates of comorbid anxiety disorders have been observed in bipolar II disorder. Consequently, the course of illness and pharmacological treatment strategies are strongly linked to the presence of anxiety comorbidity in bipolar patients.

According to this, in our case presentation we report about a bipolar young lady, emphasizing the early stages of illness as well as the anxiety comorbidities that she has suffered from.

CASE PRESENTATION

The patient, Miss M is a 32-year-old Caucasian lady employed (she works as a Carer with elderly people) and living with her husband. She presented at the ASPA clinic (Assesment and Single Point of Access, or initial psychiatric assessment) of Bedford Hospital, Bedfordshire, UK, for the assessment of her anxious and depressive feelings.

She described feelings of 'extreme anxiety' that prevented her from going out and interacting with people. This was on a background of many years history of anxiety, OCD and relapsing depression.

EM reported no childhood abuse and loving parents from a middle class family. She remembered that she was 6-8 years old when she first felt feelings of sadness. She was bullied at her private school and consequently spent a lot of time, alone in her room or at the library.

She experienced increasing levels of anxiety throughout her teenage years; as a matter of fact, she went through a course of CBT. In addition, symptoms of an obsessive compulsive disorder started at 16 years of age when she had a checking obsession; she was

constantly worrying about and checking whether the doors were locked. The anxiety was severe enough to stop her from even leaving the house to do shopping as this would trigger panic attacks. She then began to get abnormal thoughts that she called 'paranoid thoughts' in her late 20s that people were getting too close to her and she felt claustrophobic. These thoughts, as well as the panic attacks and poor sleep, have greatly reduced Miss M's social interaction.

She also had times when her mood was high; these started at the age of about 16, lasting for up to 4 days and characterised by rapid, racing thoughts, planning to do a lot of things and spending a lot of money; symptoms suggestive of hypomania. Episodes of low mood on the other hand, could last from 3-4 days to a month. Miss M could either stop eating or 'binge-eat' when depressed, and would sleep more during the day, but forcing herself to go to work; her symptoms suggestive of atypical depression. She reported having two episodes of low and high mood a year, and also signs of mixed state such as feeling agitated while depressed and tearful during high moods. The pattern of cycling between low and high moods as well as the symptoms she experiences are consistent with a rapid cycling Bipolar Affective Disorder (ICD-10, F31.8), type II, with important anxiety symptoms in comorbidity and with mixed state features.

As she grew older, Miss M started wearing 'Gothic clothes' (after developing an interest in death and related rituals) and drinking excessively in her late teens in order to forget her thoughts and feelings. Miss M reported never having taken recreational drugs. Her alcohol consumption was excessive (10-12 units per day); however since her marriage last year she has reduced this to 2 glasses of beer per week.

Around the same time, Miss M reported having visions of spirits. The first time was when she was 15 years old. She described these not as visual hallucinations, but rather as she saw ghosts. These would last from 3-4 days to a month. Miss M could either see them outside and she talks with these spirits sometimes but does not report that they talked to her.

Despite struggling with increasing anxiety, obsessive behaviour and depression throughout most of her teenage years and into adult life, Miss M never attempted or considered suicide; an important protective factor was the loss of a friend of hers two years ago who committed suicide. Consequently, Miss M does not want her husband to go through the same trauma for her.

Miss M reported a medical history of viral asthma, migraines and symptoms of IBS (Irritable Bowel Syndrome) and a positive family history of Bipolar disorder (Uncle), Schizophrenia (Mother's cousin) and Epilepsy (Grandfather). She also suffered from epilepsy as a child (from ages of 2-15 years), initially with 'grand mal' fits and then 'petit mal' fits which were treated with Epimil.

Given her past neurological history, a CT scan was arranged as a further investigation into her visions of ghosts. This revieled no abnormal findings. She was also referred to the Early Intervention Team for assessment, but this did not lead to any new findings or changes of diagnosis. With a view to controlling her increased anxiety, the dose of Fluoxetine was increased to 40mg OD (she was taking 20mg OD previously, prescribed by her GP). Finally, she was informed about choice of antipsychotic medications to use as mood stabilizer.

DISCUSSION

Miss M's case demonstrates some important aspects of the clinical trajectory of bipolar disorder. The first signs that she might have a mood disorder appeared at a young age and progressed from episodes of sadness to cycles of low and high mood through adolescence. She also developed symptoms of OCD and anxiety which have had a huge impact on Miss M's personal and social life; and the reason for her current presentation at Bedford hospital.

These stages of disease progression have been recognized previously (Duffy 2014) as has the association with comorbid anxiety disorder. Importantly, the presence of anxiety and mixed mood disorder have been shown to correlate with a worse prognosis in patients with Bipolar disorder (Kim 2014).

The challenge for clinicians is recognizing the non specific early childhood symptoms in a person with a family history of bipolar disorder. As illustrated in Miss M's case, an understanding of the developmental trajectory of bipolar disorder can ensure that the patient receives appropriate follow-up and monitoring so their symptoms can be better controlled to improve quality of life.

An important question still left to answer is how exactly the presence of comorbid anxiety disorders lead to a worse prognosis in bipolar disorder patients. A deeper understanding of the relationship between these mood disorders and their stage of development will hopefully lead to better care of patients with bipolar disorder from a younger age.

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