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Atypical Symptoms of Early Onset Bipolar Disorder

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Abstract

Juvenile bipolar disorder can be a challenging diagnosis, given its atypical presentation and tendency to have other comorbid psychiatric disorders. In this case study, we describe a case of a young patient with some atypical symptoms of early-onset bipolar disorder.

Keywords

Early Onset Bipolar, Child Psychiatry, Atypical

1. Background

Diagnosing bipolar disorder in adolescents can prove to be challenging for clinicians; due to its fluctuating course and the lack of typical symptoms and features that characterise the classical illness [1]. It is not uncommon for dissociative symptoms to be present in different mood disorders, including bipolar disorders [2]. A case series that was published in 2003, described how conversion (dissociative) symptoms can precede the onset of bipolar disorder, citing three young patients as examples [3].

The prevalence of bipolar disorder in young children is probably under reported, and it can be problematic to recognise and manage due to several reasons. It shares a lot of symptoms with the—relatively—more recognised attention deficit hyperactivity disorder (ADHD) and other childhood disorders [4].

Young people with a positive family history of bipolar disorder have double the risk of developing the illness, and the risk is even greater if the family history is that of an early-onset bipolar [5].

2. The Case

Mikasa (not patient's real name) is a pleasant 16-year-old girl who initially pre-

sented with symptoms of anxiety and panic attacks. Before referring her to Young Adult Mental Health Services (YAMHS), her GP started her on Fluoxetine. At the time Mikasa was reporting some level of distress both from home and school. She is a bright student, one that gets top marks, but she also tends to place so much pressure on herself. After two weeks of antidepressant treatment, she started to experience some dissociative/conversion-like symptoms; shoeless and dressed only in her pyjamas, she left the house in the early morning hours to go shopping. In the shop, she got very emotional and started crying after she found that the ice-cream popsicles were not kept in the freezer and went on to have an argument with the shop assistant. On her way back home and upon seeing a stray cat she became so happy and immediately decided to take her home. Mikasa is usually level-headed and acting emotional and impulsive was so out of character for her. She remembered this incident but could not understand why she behaved like this.

Mikasa was also filmed moving her arms and upper body rhythmically as if dancing in a trance-like state. She reported having no control over her body during these episodes and feeling "elated" and euphoric just before these movements starts. She also had no recollection of these episodes.

An increase in dose of Fluoxetine (from 10 mg to 20 mg) has coincided with and very likely precipitated a state where Mikasa became elated, easily irritable, impulsive, talkative, and overfamiliar. She also told us that she was texting her male colleagues, drinking alcohol, and was preoccupied with thoughts of sexual nature. All these behaviours were out of character and luckily, she did not engage in any sexual acts during these episodes. Mikasa's mood then kept alternating between spells of elevated mood and periods where she struggles with anxiety, panic attacks and low mood. She did not seem to have distinct/clear episodes of hypomania or depression but rather had a mixture of these symptoms in a short span of time and kept switching in and out of feelings of low mood, irritability and anxiety and periods of happiness and overactivity. Fortunately, Mikasa always retained her insight and had no psychotic symptoms; when Young Mania Rating Scale (YMRS) was administered, she had a score of 21.

Collateral information confirmed that Mikasa achieved normal developmental milestones and that her parents had no concerns about her growing up. She has a history of a significant Traumatic Brain Injury (TBI) resulting in a basal skull fracture. This happened when she was one year old. Her mother was unsure if her aunt has bipolar affective disorder or borderline personality disorder (BPD).

Because of the conversion-like symptoms that Mikasa was experiencing, we have arranged for her to have an Electroencephalogram (EEG) and a referral to neurology to rule out any seizure activities. They ended up doing a CT-Brain, which detected no abnormalities. It should be noted that these symptoms have abated when Fluoxetine was stopped; Mikasa was on Fluoxetine for a total of 3 - 4 weeks. However, symptoms of mixed states and rapid cycling mood swings continued and did not stop until she was started on Olanzapine.

Mikasa has been on Olanzapine 5 mg—nocte for 2 weeks now, she reported good compliance and no side effects from same. She is no longer experiencing those rapid cycling mood swings and described her mood as "more settled" on her last appointment. She continues to see YAMHS Psychologist for Cognitive Behavioural Therapy (CBT) sessions and is doing well at present.

3. Discussion

In the past, childhood bipolar disorder was thought of as being rare diagnosis. However, more recent evidence shows that up to two thirds of adults with bipolar disorder report childhood or adolescent onset of affective symptoms [6]. Therefore, early recognition and management of bipolar disorder are essential for good psychosocial functioning and satisfactory treatment outcome.

In a recent study, a total of 505 participants with bipolar mood disorder were recruited to investigate the link between Traumatic Brain Injury (TBI) and bipolar disorder. Thirty-seven patients (7.3%) recalled a premorbid traumatic brain injury. On average, it took about 8.9 years for symptoms of bipolar disorder to develop after the traumatic brain injury [7]. In Mikasa's case, symptoms of bipolar disorder developed 16 years after the TBI. Establishing a causative relationship between TBI and bipolar disorder is beyond the scope of this paper. What can be recommended here is to ask about history of head injuries when assessing a child for possible bipolar disorder.

Bipolar disorder is a complex illness with a multifactorial aetiology. In this case, it is possible that the history of TBI, psychosocial stress, use of antidepressant medication and the likelihood of a close relative having the condition (genetic loading), are all factors that have contributed to Mikasa developing bipolar disorder.

Antidepressants are commonly prescribed for symptoms of conversion disorder and anxiety. To minimise the risk of antidepressants precipitating a manic/hypomanic episode, clinicians should assess carefully for possibility of an underlining bipolar disorder. Antidepressants have the propensity to disrupt mood and through different mechanisms—can trigger episodes of mania or hypomania [8]. Patients with early onset bipolar and those with strong family history of the illness may even be at greater risk [9].

The association between the use of antidepressants and development of manic spectrum symptoms is well-established. The rate of antidepressant induced manic switching in patients below the age of eighteen is reported to be 5.4%; with children in their peripubertal phase having the highest risk [10].

Even when the dissociative symptoms are not enough to meet the diagnostic criteria, they can be indicative of the presence of some juvenile psychiatric disorders such as bipolar affective disorder [11]. Conversion/dissociative symptoms in adolescents can sometimes be an early sign of an early onset bipolar disorder.

Clinicians should familiarize themselves with the atypical presentation of bipolar disorder in adolescents, obtain detailed family and medical histories and

perform investigations as deemed appropriate to rule out organic causes that could explain the symptoms.

Consent

The patient and parent have both given verbal and written consent to the publication of this paper following an explanation of the procedure. Patient anonymity has been protected.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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