

Case Report

Managing a Young Adolescent with Bipolar Disorder: An Experience from Nepal

Bina Gurung, Anoop Krishna Gupta*, Robin Jha and Utkarsh Karki

Department of psychiatry, National Medical College and Teaching Hospital (Trivuvan University), Nepal

***Corresponding author**

Anoop Krishna Gupta, Department of psychiatry, Lecturer, National Medical College and Teaching Hospital, Birgunj, Nepal, Bhedyahi, Birgunj-18, Parsa, Nepal, Tel: 00977-9842060809, Email: dranoopkrn@gmail.com

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Abstract

Bipolar disorder (BD) is a common psychiatric problem in youths and can pose a challenge in diagnosis in children and adolescents. The diagnosis of Youth Bipolar Disorders is complicated due to the various overlapping symptoms shared by other psychiatric disorders like attention deficit hyperactivity disorder (ADHD). Varying presentation, having ill defined diagnostic criteria and increased comorbidity are the major challenges faced for the assessment of the BD in early teens. We report a case of a 13 year old boy, who presented with decreased sleep, over talkativeness, distractibility, hyperactivity in the form of increased dancing and singing, irritable mood and inflated self-esteem in the absence of positive family history. He was diagnosed as BD by using DSM-5 criteria and after repeated mental state examinations, rating scale, exploring history from parents, family members and teachers. Though diagnosis might not be difficult in an American setup, it is difficult here because of the educational and cultural background. There was significant improvement in his illness following two weeks of treatment with olanzapine, lithium and behavioural techniques but the maintenance of remission is quiet challenging in the socio-economic scenario of Nepal.

ABBREVIATIONS

ADHD: Attention Deficit and Hyperactivity Disorder; PBD: Pediatric Bipolar Disorder; BD: Bipolar Disorder; DSM: Diagnostic and Statistical manual of Mental disorders; YMRS: Young Mania Rating Scale

INTRODUCTION

As per synopsis of psychiatry, Bipolar disorder is a mood disorder characterised by the recurrent and episodic presentation of mania and depression which deviates an individual from his or her usual behaviour and functioning [1]. The overall rate of PBD was documented as approximately 1.8% [2] worldwide but the lifetime prevalence of PBD reaches up to 2.1% [3] in developing countries. Lewinsohn et al [4] found that the incidence of PBD is highest at adolescent (14 years of age) and then gradually decreases. A study performed by Shakya [5] in Nepal demonstrated that approximately 12% of psychiatric out-patient patients were reported as PBD. The nature of PBD varies from that between an adult and a child and the closest differential diagnosis of PBD is Attention Deficit Hyperactivity Disorder (ADHD) (Table 1). The presence of discrete mood episodes, symptoms being present solely during a mood episode and increased goal directed activities guided us to rule out ADHD.

Similarly, symptoms being episodic and inconsistent with child's baseline behaviour ruled out behaviour problem of ODD.

Manic symptoms of youths have been reported to be distinguishable from those of adults. Markedly labile moods, persistent, irritability, erratic behaviours and mixed manic and depressive features are frequently observed in Bipolar disorder (BD) youths [6]. Diagnostic process may be difficult and complicated in children who usually do not meet the full criteria for mood disorder episode due to overlapping symptoms of other disorders such as Attention-deficit hyperactivity disorder [7], oppositional defiant disorder, disruptive mood dysregulation disorder, anxiety disorders and other mood disorders. Child and adolescents rarely experience clear-cut episodes of mania/hypomania and depression, interrupted by period of normal functioning like adults [8]. Younger people are found to experience chronic irritability, aggressive behaviour, impulsivity, extremely rapid mood swings, hyperactivity, and severe temper tantrums [9].

CASE PRESENTATION

We want to report a case of a thirteen year old male from lower socioeconomic status with well-adjusted premorbid temperament without any co-morbid physical or psychiatric

Table 1: Differences between Bipolar disorders and Attention Deficit Hyperactivity Disorder.

Differentiating points	BD	ADHD
1. Symptoms in the absence of acute mood episode (inter-episodic state)	Generally absent	Generally present
2. Relation to mood state	Symptoms generally present when in euphoria or sadness	Symptoms are better noticed when euthymic state
3. Predominant mood state during excited episode	Euphoria/cheerful	Irritability
4. Distinct mood episode	Mostly present	Mostly absent
5. Associated psychosis	Usually present	Absent

Abbreviations: BD: Bipolar disorders; ADHD: Attention Deficit Hyperactivity Disorder

disorder and without family history of psychiatric illness. He presented to our out-patient department with complaints of singing loudly and dancing excessively, talkativeness, restlessness, impulsivity, verbally abusive and aggressive when provoked. He also had labile affect, inflated self-esteem, over familiarity and decreased need for sleep for four months. He was not given any medication throughout this period of illness as family members were busy visiting faith healers and doing sacrifices in local temple that proved to be of no use. During index (last) episode, he expressed grandiose ideas, over familiarity and increased demands for delicious food items and new cloths. Upon in-patient admission, his mental state examination revealed distractibility, restlessness and cheerful affect. Because of his goal directed activities and interepisodic remission, we considered BD instead of ADHD. The adult version of Young's Mania Rating Scale (YMRS) which was provider-administered scale with 11-item was used to rate the symptoms. The score was 24 at the time of admission.

On careful review of the past history, it was found that the first episode of illness had started abruptly two years ago which was characterized by obscenity and disinhibition in addition to above mentioned symptoms that lasted for twelve days. Organic causes and substance abuse was ruled out by history and neuroimaging (Computed Tomography of head) at that time. He was treated at a local hospital with drugs, the details of which was not recalled. He stopped medications after about three months as no significant improvement was observed. During that time, family members would tie him by wrist and feet assuming that he was mischievous. He had gradually reached like his premorbid state in further six months without medications. The second episode occurred after two months and was characterized by persistent sad mood, loss of interest and enjoyment, refusal to go to school and diminished activity, decreased communication for almost ten days continuously. Other associated symptoms were sleepiness and decreased appetite which improved on its own. Three similar episodes were observed then in one year duration but no medical treatment was taken. Inter episodic recovery was complete as per family members.

Olanzapine 10 mg and clonazepam 2 mg per day was initiated immediately after admission. He had labile affect as he would cry intermittently upon critical comments passed by family members and would laugh after few minutes. As there was no improvement after a week of treatment, olanzapine was increased to 20 mg and then to 30 mg per day. Additionally, lithium was started which was increased to 600 mg per day. It is important to mention that serum lithium monitoring is not available at our place. He

developed sedation but he continued to talk more than premorbid self. In addition to drugs, he was also provided supportive sessions during crying spells by the treating consultant. Family members had started showing expressed emotions in the form of criticism and ill behaviour. Thus his family members were counselled regarding the need to behave well with the patient. They accepted that their criticism had worsened his symptoms in past but they were unable to dump their personal 'frustration' on to the patient. The patient was taught to control his excessive demand of food. He was kept engaged by helping out the nurses on ward duty. At times, time out technique was used to control his temper tantrums. After about ten days of treatment, he showed increased attention span, decreased restlessness, slowed speech rate and improved sleep. However his mood remained elated. His YMRS score decreased to 10 when assessed after 12 days of in-patient treatment. Patient and relatives were not willing to stay further in the hospital because of financial difficulty which is a regular scenario in this part of the world. The absence of health insurance system and poor socioeconomic status of psychiatric patients has resulted in poor compliance with treatment at places like Nepal and northern India. Despite good compliance, there was worsening of symptoms a month after discharge. His father came and asked for medicine which was cheaper than olanzapine. Chlorpromazine was prescribed. Olanzapine was tapered and lithium was continued. After 2 months of follow up he maintained compliance and had attained remission. He is expected to visit after 2 months. Though he is compliant with medicines, the relapse seems impending because of the ill behaviour and comments by the family members.

DISCUSSION

Though thirteen year old does not come under paediatric age, it is not a regular affair to witness mania with psychotic symptoms at this age in this part of the world. Another point is that diagnosing such case becomes difficult here because of the poor history and educational background of the family members. Family members also conceal part of the history because of shame, stigma and as a part of faith healing process. We found this case to have clear cut past episodes of mania and depression with period of normal baseline functioning but with much difficulty and repeated examinations of several caretakers/stake holders. This fact can be criticized as 'incompetence in diagnosis' but this is a common difficulty faced by psychiatrists in terai belt of Nepal where resources and education are minimal. Overall, this case was unique to us because of two more reasons. First of all, we have only few cases of young adolescent BD at our centre

and second that this case represented a similar picture of adult bipolar disorder from the very onset of illness. Surprisingly, no family history of BD was found which is common with young onset BD. It is needless to say that the risk of further episode in this patient was highlighted to family members. In a scenario of psychiatric illness, poor economic status and long term treatment, who should be blamed for the likely relapse in this patient is still to be answered.

DSM-5 and ICD 10 are universally used for the diagnosis of psychiatric illness. However, they lack standard criteria for the diagnosis of PBD. So the need for the standard diagnostic guideline is need of the hour. In addition to above points, we would also like to mention that there is still lack of accurate figure of prevalence and distribution of PBD in Nepal. Very few studies have been conducted so far. Therefore the urgency to investigate the current epidemiological scenario of PBD in Nepal is needed where the standard diagnostic tools and accurate scientific methods are applied.

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