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# BIPOLAR MOOD DISORDER WITH MALADAPTIVE BEHAVIOURAL PATTERNS; CLINICAL SEVERITY AND TREATMENT HURDLES: A CASE REPORT

Psychiatry

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KEYWORDS

## INTRODUCTION

Mood episodes with Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-5)- defined mixed features are highly prevalent in Bipolar Disorder (BMD) affecting nearly 40 % of the patients during their illness course(1). The coexistence of depressive and manic symptoms or the rapid alternation between these symptoms during the same time period has been considered a more severe form of mood episode than either one of these states alone. Mixed states are often protracted beyond acute episodes, psychotic symptoms are common, is associated with poorer clinical outcomes, has greater treatment resistance, higher rates of comorbidity, more frequent episodes, and increased suicide rates(1).

While it is widely known that the bipolar spectrum has a strong genetic and biological basis, numerous psychosocial factors have also been shown to impact both initial onset and episode recurrence(2). The occurrence of recent life events has been studied as a possible trigger of bipolar mood symptoms. Goal-attainment life events would appear to be a specific ingredient in the buildup to mania, while negative events would appear to raise the risk of depression. The cognitive vulnerability–stress model attempts to explain the connection between life events and affect. A number of dysfunctional cognitive styles have been identified in bipolar disorder, notably including pessimism and a contradictory pattern of self-esteem, ruminative processing of positive and negative affect, active rejection of advice, feelings of superiority, hypersensitivity to criticism, and more. These cognitive particularities may provide clues to the relationship between cognitive style, life events and affective symptoms. According to schema theory, individuals who face toxic, maladaptive experiences in early childhood tend to develop a series of Early Maladaptive Schemas (EMSs) that are coherent with these experiences(2). This case report focuses on treatment hurdles of a patient with Bipolar Mood Disorder, who had a negative life event prior to the onset of the episode along with maladaptive behavioural patterns.

### Case Report

A 31year old female patient presented to psychiatry outpatient department of SMIMER hospital, with chief complaints of sadness of mood, disinterest, decreased sleep and appetite, easy irritability, mood lability, passive death wishes, suspiciousness towards family members and constantly demanding to meet her husband with whom she was separated 2-2.5 years back. The patient had an interpersonal issue with her husband and her in laws within a few days of her marriage, after which the patient was sent back to her parent's home. Following this, the patient started to remain sad and gloomy throughout the day, would stay alone and would not interact with any of her family members, suspiciousness towards her parents that they wanted to separate her from her husband. The patient in between would run away from her home and go to her husband's house where she stayed for few days on the road waiting for her husband. With these complaints, the patient was started on psychiatric treatment but with no significant improvement. The patient was then brought by her relatives involuntarily to SMIMER Hospital, Psychiatry OPD, after which the patient was admitted to the psychiatry ward. After, detailed evaluation and investigations, the patient was started on Injection Haloperidol and Inj. Promethazine to calm her as she was reluctant to take oral medications. Then gradually the patient was shifted on T. Olanzapine (5) + T. Fluoxetine (20), T. Sodium Valproate (200) 1-0-1 and T. Clonazepam (0.5) 1 tab SOS. But after few days, with increasing dose up to optimal level and changes in medication, the patient did not show improvement with increasing irritability in between, threatening to meet her husband, mood liability, would start to talk in English in between conversations, so the patient was started on Electro-Convulsive Therapy (ECT). The patient had to be given 13 ECTs after which improvement was noted after 45 days of admission. After, 1-2 follow-up OPD visits, the patient had stopped treatment for few days, and again her symptoms worsened, but the patient improved within few days of starting treatment again. On routine follow-up, the patient was stable with T. Olanzapine (10 mg) 1 HS, T. Clozapine (50 mg) ½ in the morning and 1 at night, T. Lithium (300 mg) 1 BID, T. Sodium Valproate (500 mg) 1 HS, T. Trihexyphenidyl (2 mg) 1 BID, and T. Clonazepam (0.25 mg) 1 in the morning and 2 at night. But, in the recent few days, the patient again worsened while on medications and is currently admitted in the psychiatry department of the SMIMER Hospital.

During her hospital stay, the patient was tested for IQ by clinical psychologist which showed her IQ in the dull normal range (85%-95%). Also, a personality assessment was done by clinical psychologist, which showed maladaptive behavioural patterns of coping in the patient. The patient had also undergone MRI Brain scan which showed no abnormality.

The patient's mother also had a H/O psychiatric illness immediately after her own marriage, for which she had taken psychiatric treatment along wih ECTs. No other family member had any psychiatric illness.

## DISCUSSION

Bipolar Mood Disorder (BMD) represents a complex psychiatric condition characterized by mood episodes that encompass manic, depressive, or mixed features. This case report sheds light on the challenges encountered in treating a patient with BMD who exhibited maladaptive behavioural patterns and a history of negative life events.

The patient in this report presented with a mixture of depressive and manic symptoms, a clinical presentation often referred to as a "mixed state." Such states are known for their severity, prolonged duration, and increased likelihood of psychotic symptoms. It is crucial to recognize and address mixed states promptly due to their association with poorer clinical outcomes and heightened resistance to treatment (3). This case underscores the need for tailored interventions for individuals experiencing mixed states of BMD.

Furthermore, the patient's history of early life stressors and interpersonal issues before the onset of her illness highlights the influence of psychosocial factors on the course of BMD. These factors,

when combined with a genetic predisposition, can significantly impact the onset and recurrence of mood episodes (4). It is essential for clinicians to assess both biological and psychosocial contributors to BMD and consider personalized treatment plans that address these aspects.

Cognitive styles and early maladaptive schemas (EMSs) also play a role in understanding the complexity of BMD. The patient's maladaptive behavioural patterns, including suspicion, withdrawal, and an intense desire to reunite with her husband, reflect cognitive vulnerabilities often seen in individuals with bipolar disorder. These cognitive features may contribute to the difficulty in managing the illness and should be integrated into the therapeutic approach (5).

Regarding treatment, the patient's journey was marked by several hurdles. Initial pharmacotherapy with antipsychotics and mood stabilizers did not yield significant improvement. This highlights the clinical challenge of managing patients with severe and treatment-resistant BMD. In such cases, Electroconvulsive Therapy (ECT) emerged as a viable option, ultimately leading to substantial improvement in the patient's condition. The decision to administer ECT should be carefully considered, and its efficacy in this case underscores its role in managing refractory BMD (6).

Psychological assessments revealed that the patient had an IQ in the dull-normal range and displayed maladaptive behavioural patterns. These findings emphasize the importance of comprehensive assessments that consider cognitive functioning and behavioural traits to inform treatment strategies. It also underscores the potential hereditary aspect of the disorder, given the history of psychiatric illness in the patient's mother.

## CONCLUSION

To conclude, this case report illustrates the clinical complexity of Bipolar Mood Disorder, particularly when mixed states and maladaptive behavioural patterns are present. It emphasizes the importance of recognizing and addressing both biological and psychosocial factors in the assessment and treatment of BMD. The use of ECT, in conjunction with pharmacotherapy, demonstrated efficacy in this challenging case. Further research is warranted to explore the interplay of cognitive vulnerabilities and early maladaptive schemas in the context of BMD and to develop more personalized treatment approaches.

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