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BIPOLAR AFFECTIVE DISORDER: MANIC SYMPTOMS

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ABSTRACT:

The subject of this case study is Mrs. P, a woman in her 57th year who has been diagnosed with bipolar affective disorder (BPAD), primarily experiencing manic symptoms. BPAD is a long-term mental health condition that impairs social, professional, and interpersonal functioning. It is marked by periods of mood elevation (mania or hypomania) and depression. With a history of episodic mood disorders spanning the previous four years, Mrs. P's clinical presentation is distinctive for her irritability, excessive talking, compulsive material collecting, emotional labiality, and decreased need for sleep. Her medical history has been characterized by intervals of clinical relief interspersed with relapses, frequently brought on by irregular medication compliance. Significant psychosocial stressors, such as her husband's long-standing alcoholism and the devastating loss of her daughter soon after her divorce, have further exacerbated Mrs. P's condition. She has a family history of schizophrenia, so these pressures have probably added to the complexity and persistence of her symptoms.

The purpose of the case study is to investigate the relationship between Mrs. P's psychosocial environment and her mental health symptoms, specifically focusing on how pressures in life might both cause and prolong manic episodes. It emphasises the value of all-encompassing and ongoing care, which includes supportive therapies in addition to pharmaceutical interventions like antipsychotics and mood stabilizers. Her ability to better stick to her treatment plan and take care of her symptoms at home was greatly enhanced by family support and instruction. The study highlights the difficulties in treating BPAD in an older adult who also has chronic stressors and coexisting medical illnesses. This highlights the necessity for a multifaceted approach to treatment that takes into account the biological and psychosocial aspects of the patient's disease. In order to ensure that relapses are avoided, it also highlights the necessity of ongoing monitoring and care. Our goal in presenting this case is to advance knowledge about the management of BPAD, especially in situations when social and familial dynamics are critical to the patient's health.

KEYWORDS:

BIPOLAR AFFECTIVE DISORDER (BPAD), MANIA, MOOD DISORDERS, PSYCHOSOCIAL STRESSORS- MEDICATION ADHERENCE, FAMILY HISTORY OF SCHIZOPHRENIA, ALCOHOL DEPENDENCY, EMOTIONAL LABILITY, OLDER ADULT PSYCHIATRY, PHARMACOLOGICAL TREATMENT,SUPPORTIVE THERAPY

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INTRODUCTION

Mania/hypomania and depressive episodes are the hallmarks of bipolar affective disorder (BPAD), which significantly impairs social and professional performance. Elevated mood, increased activity, impatience, and decreased desire for sleep are common characteristics of manic episodes. The illness frequently has a chronic course with intermittent remissions. The subject of this case study is Mrs. P, who has a history of sporadic mood disorders and now exhibits mania symptoms. In order to manage BPAD, the study intends to investigate how psychosocial stresses and family dynamics interact. Supportive therapy and continuous medication adherence are crucial for this process.

CASE DESCRIPTION

Mrs. P is a 57-year-old married woman who has spent the last 25 years taking care of her family. She holds a bachelor's degree in commerce. She have a friendly relationship with her kid and resides in a nuclear household with her husband, who has a history of alcohol dependency syndrome. The patient has a history of schizophrenia in her family. Her husband's long-term alcoholism and the death of her daughter were two major family stresses that contributed to her condition's decline approximately four years ago. A slow emergence of mood disorders ensued after these incidents.

HISTORY TAKING

- Chief Complaints: Mrs. P presented with excessive anger, persistent engagement in activities, collection of waste materials for craft projects, excessive talking, over-friendliness, and emotional labiality (alternating between laughter and crying).

- History of Present Illness: Mrs. P's symptoms started approximately four years ago, with periods of increased irritability and arguments with her husband. This phase was followed by episodes of low mood, withdrawal, and excessive sleep. Despite initial treatment for BPAD, she discontinued medication due to perceived improvement. In 2023, she experienced a relapse characterized by compulsive behavior (collecting waste for crafts), irritability, and insomnia, leading to hospitalization.
- Past Psychiatric History: Diagnosed with BPAD in 2019, Mrs. P's adherence to treatment has been inconsistent, with periods of symptom remission and relapse.
- Medical History: She has a history of hypertension, managed with medication, and underwent nasal surgery in the past.
- Family History: The family history is significant for schizophrenia and her husband's alcohol dependence. Her daughter's death in 2020 was a notable emotional stressor.
- Personal History: She completed a B.Com and has been a homemaker since her marriage at the age of 20. She has no history of substance use and exhibits no history of suicidal behavior.
- Premorbid Personality: No clear information could be elicited regarding her personality before the onset of symptoms.

INVESTIGATION

Mental Status Examination: Mrs. P seemed inattentive and talked too much. Her disposition was erratic and angry. She didn't explicitly show signs of hallucinations or delusions, but instead showed disordered thinking that was directed towards her craft pursuits. She didn't have much understanding of the ailment, especially when it came to the requirement for regular medicine.

Physical Examination: No abnormalities were detected apart from findings consistent with her history of hypertension.

TREATMENT AND FOLLOW-UP

Pharmacological Management: Mrs. P was prescribed mood stabilizers (e.g., Lithium or Valproate) to manage her manic symptoms and prevent further mood fluctuations. Antipsychotic medication (e.g., Olanzapine) was used to address her agitation and reduce irritability.

Supportive Therapy: Individual counseling focused on improving insight into her illness and addressing grief related to her daughter's death. Family therapy sessions were initiated to educate her husband and son about BPAD, emphasizing the importance of a supportive home environment and medication adherence.

Behavioral Interventions: Structured daily routines were encouraged to reduce her compulsive behaviors, including time management strategies for her craft projects and promoting household order.

Follow-up: Mrs. P was closely monitored over three months, with gradual improvement in her irritability and sleep patterns. Her adherence to medication improved with support from her family. However, ongoing stressors related to her husband's alcohol use remained a challenge.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis for Mrs. P, a 57-year-old woman presenting with symptoms of emotional instability, compulsive behaviours, excessive talking, irritability, and decreased need for sleep, covers other illnesses with similar features. The following are possible differential diagnoses:

BIPOLAR AFFECTIVE DISORDER (BPAD) - MANIC EPISODE

Given her history of episodic mood elevation and depression over the last four years, this is the most plausible diagnosis. Her current symptoms, which are indicative of a manic episode, include impulsivity, decreased need for sleep, irritability, and excessive talking. The chronicity and varying course lend additional credence to BPAD.
BPAD is characterised by discrete episodes of depression and high mood (mania/hypomania), which are frequently brought on by or made worse by psychosocial stressors. The history of a partial response to antipsychotic and mood stabiliser medication also lends credence to the diagnosis.

SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE

In addition to psychotic symptoms such as delusions or hallucinations that are not exclusive to mood episodes, this diagnosis can also manifest as mood symptoms such as mania or depression.
Schizoaffective disorder is less likely because Mrs. P's background lacks evidence of hallucinations, persistent delusions, or cognitive disorders outside of mood episodes. In addition, this diagnosis is ruled out by the lack of enduring psychotic symptoms other than mood disorders.

MAJOR DEPRESSIVE DISORDER WITH MIXED FEATURES

Mixed-feature major depressive disorder (MDD) is characterised by depressive symptoms together with aspects of mania or hypomania, such as talkativeness, irritability, or increased activity.
Although Mrs. P has previously gone through depressed episodes, her current state of enhanced mood, increased activity, and decreased need for sleep points more towards a more prominent manic phase than to mixed-symptom MDD.

OBSESSIVE-COMPULSIVE DISORDER (OCD)

It is possible to misunderstand Mrs. P's waste material collection behaviour as obsessive-compulsive behaviour, which is frequently seen in OCD.
In contrast to OCD, Mrs. P's actions are motivated by a

frenetic feeling of creativity and purpose (such as crafting) as opposed to bothersome, upsetting obsessions and compulsions. Furthermore, the significant mood swings observed in Mrs. P's instance are absent from OCD.

PERSONALITY DISORDERS (E.G., BORDERLINE PERSONALITY DISORDER)

Mood swings, impatience, and impulsive actions are common symptoms of personality disorders including Borderline Personality Disorder (BPD).

Although they are not as prominently documented in Mrs. P's past, unstable relationships, identity disorders, and persistent feelings of emptiness are common long-term patterns of BPD presentation. Her symptoms are not consistent with a pervasive personality problem, but rather with an episodic mood illness.

DEMENTIA WITH BEHAVIORAL DISTURBANCES

In older persons, mania can be mimicked by behavioural and psychological symptoms of dementia (BPSD), such as disinherited behaviour, irritation, and increased activity.

While dementia usually comprises a steady cognitive decline with more frequent behavioural alterations, Mrs. P's symptoms have been episodic and clearly respond to mood-stabilizing medication. Mrs. P does not appear to be experiencing any notable memory loss, cognitive decline, or executive function problems.

DISCUSSION

This case study demonstrates how difficult it may be to manage BPAD when there are strong psychosocial stressors and complicated family relationships present. The subtle beginning of manic symptoms in Mrs. P's instance is also noteworthy; these symptoms were brought on by her husband's long-term alcoholism and were made worse by the emotional pain of losing her kid. This is consistent with research that shows a direct correlation between stressful events in life and the development or worsening of bipolar symptoms.

A manic episode, which is typified by irritability, excessive talking, and a decrease in the need for sleep, is consistent with Mrs. P's presentation. Although atypical, her obsessive collecting behaviour may be seen as a continuation of her manic episodes' heightened activity and distractibility. Bipolar illness medication non-adherence is a well-documented difficulty. Mrs. P's relapse episodes throughout her non-compliance highlight the significance of ongoing pharmacological therapy in preventing recurrence of symptoms.

An additional level of complexity is created by the existence of a family history of schizophrenia, which may point to a hereditary susceptibility to mood problems. Furthermore, the loss of her daughter might have caused a serious psychological trauma, which would have resulted in a depressed episode in the years that followed. The significance of a comprehensive treatment strategy in the management of long-term mental health disorders is shown by the improvement in symptoms that occurs with regular medication and family support.

CONCLUSION

The case of Mrs. P highlights the complex difficulties in dealing with Bipolar Affective Disorder, especially when major familial pressures are added to the mix. In order to achieve stability, the case highlights the significance of supportive therapy, psycho education, and medication adherence. To guarantee long-term stability, future management should concentrate on upholding adherence, lowering environmental stresses, and cultivating a positive family dynamic.

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