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CASE REPORT

Bipolar disorder - difficulties in managing emotional ups and down in an entertainer life: a case report

Arlisa Wulandari[1*], Meily D Kusuma[2], Rachmaditya Pancarani[2]

1) Department of Psychiatry, Faculty of Medicine, Universitas Jenderal Achmad Yani, Cimahi, Jawa Barat, Indonesia.
2) Medical Undergraduate Study Program, Faculty of Medicine, Universitas Jenderal Achmad Yani, Cimahi, Jawa Barat, Indonesia

*Corresponding author. E-mail: arlisawulandari@yahoo.com

ABSTRACT

Bipolar disorder is a chronic and recurrent disorder, a brain disorder that causes changes in a person's mood, energy, and ability to function. Patients have alternate increased mood and activities (mania, hypomania, or "ups" period) and declining mood and activities (depressive or "downs" period) in their life. Symptoms of the manic episodes of bipolar disorder include sensitive feelings, lack of rest, and shot up self-esteem, while the depressive episodes bring loss of interest, more or less sleep than usual, anxiety, a feeling of worthlessness, and lack of concentration. Bipolar disorder is a severe mental disorder with a fairly high prevalence of 1%-2% and is the 5th cause of disability in the world. Many factors have been considered to contribute to this disorder. While there is strong evidence that some genetic and environmental factors are associated with bipolar disorder, only a few can provide sufficient evidence to establish causality. This report discusses the case of a new manic episode of bipolar disorder that occurs in a woman aged 25 years old who works as a public figure, announcer, and entertainer. The patient has been hospitalized several times and received various pharmacotherapy and psychotherapy but still having difficulties in managing the ups and downs of her emotion. A lot of individual factors must be considered in managing patients with bipolar disorder.

Keyword: bipolar disorder, downs period, emotion, entertainer, ups period

INTRODUCTION

With the current development of awareness among society, people now pay more attention to mental health. As documented by a substantial body of evidence, mental health is affected by a variety of factors, such as the environment, living habits, medical resources, and experience.[1,2] The top 5th mental health problems in 2017 are depression, anxiety, schizophrenia, other mental disorders, and bipolar. There has been a significant increase in bipolar cases in the last three decades in Indonesia.[3] Bipolar disorder (BD) is a chronic disorder of abnormal mood characterized by episodes of elevated or depressive mood, or, less commonly, a mixed affective presentation. People with

BD experience these phases of feeling in their lives.[4,5] Based on the Diagnostic and Statistical Manual (DSM) V, bipolar disorder is divided into two: (1) bipolar I and (2) bipolar II disorders. Bipolar I disorder is characterized by two distinct episodes, namely manic and depressive episodes; whereas bipolar II disorder is characterized by hypomanic and depressive episodes. In contrast, the PPDGJ III, which is the Indonesian Guideline for Mental Disorder Diagnosis, categorizes bipolar disorder into different classifications based on the current episode experienced by the patient. BD consists of increased affect, as well as excessive activities (mania or hypomania) followed by decreased mood. The Indonesian diagnostic guideline for bipolar affective disorder stated that for manic episode with psychotic, current episode must meet the criteria for manic with psychotic symptoms and there must be at least one hypomanic, manic, or mixed affective episodes in the past. This condition is accompanied by at least four of the following symptoms: increased activities or physical restlessness, talking more than usual or an urge to talk continuously, inflated sense of self-worth, reduced need for sleep, easily distracted, and excessive involvement in activities.[6]

Depression is defined as an emotional state that is characterized by intense sadness, feeling of worthlessness and a sense of guilt, self-withdrawing, and losing interest in usual daily activities. Depressive episodes tend to last longer, around six months, but rarely exceed a year. On the other hand, mania is defined as an emotional state with grandiosity, irritability, hyperactivity, excessive talking and thoughts, and attention distractibility. Mania can occur unexpectedly and lasts between 2 weeks to four-five months. Diagnosis of BD is difficult to be established, considering its overlapping symptoms with other psychiatric disorders like schizophrenia and schizoaffective.[7]

BD is a severe mental disorder with a fairly high prevalence of 1-2% and is the 5th cause of disability in the world. According to World Health Organization (WHO) data in 2016, 60 million people were affected by bipolar disorder. In 2019, 10.68% of the population suffered from mental health disorders, with 0.51% of the population suffered from BD. A study has revealed that the lifetime prevalence rates in the US for this disorder are 1.0% for bipolar I, 1.1% for bipolar II, and 2.4% for threshold bipolar or having a lifetime history of 2 sub-threshold hypomanic episodes. Thus, the overall prevalence of BD in the US population is 4.4%. In Indonesia, 0.34% of the population, or 909,393 people, suffered from BD in 2019. The onset age of BD varies approximately between 20 and 30 years, with a similar prevalence rate in men and women in all cultural and ethnic groups.[8,9] People with bipolar disorder also face the danger of death that may be caused by, among others, suicide. This disorder usually begins in early adulthood, but it can also occur in childhood.[10]

With the increasing number of bipolar cases, it is necessary to expand research on the factors influencing mental health with a focus on social capital.[11] Social capital comprises of resources that individuals or collectives mobilize to achieve their interests.[12,13] Social capital can be also viewed as the features of family, peers, community, school, and work. Although there is no consensus on the concept and classification of social capital, there are common elements, such as formal and informal relationships, mutual assistance, trust, and social participation. In addition, social capital may affect an individual's mental health by influencing their attitude to life and habits.[14,15,16]

CASE ILLUSTRATION

A 25-year-old married woman who had a long story of both depressive and manic episodes was presented. A review of symptoms indicated that she indeed has experienced multiple depressions beginning in her early teens. The first symptoms appeared 10 years ago in the form of depression. The symptom was accompanied by tantrums and hallucinations. She mentioned that she saw the late fater and late sister figures during that time and she became depressed. These symptoms got worse about a month before she was first hospitalized in 2012 because she was triggered by her study on the Holy Qur'an regarding surah that explains about the Jinn Race or Demons as spiritual beings, which led to her imagining the Judgement Day. She was hospitalized for the first time in Dr. Hasan Sadikin General Hospital and she had been variably diagnosed as having major depression, bipolar disorder, and psychosomatic disorder. She was treated with risperidone and trihexyphenidyl, experienced improvement, and went home after the 24th day of treatment.

In 2013, when she was 16-year-old, she married a 32 years old man introduced by her mother due to the religious belief held by the family that someone with an illness should marry to cure their ilness. But a year after the marriage, she failed to keep her marriage and was divorced. In the same year, she also refused to continue her education to Senior High School and took school acceleration program to go to college. She then managed to continue her education at a private university but she did not finish it. .This made her feel very traumatized and depressed.

In 2014, she got a job and worked as an announcer in one of the Indonesian television stations. At first, career was great, she had a lot of job offers, went for auditions, and won the 2nd place in a local pageant. She was good at communication, and none of her friends knew about her disorder.

After years without symptoms, she came back in 2015 because she was suicidal and wanted to end her life. She lost interest, felt sad all the time, and felt hopeless. She experienced the symptoms for about 3 months and her suicidal thought became stronger with time. Symptoms began to appear when she failed to marry her boyfriend who worked as an anesthetist in Egypt. They met on social media, but he had an affair that they cancelled the wedding. She also had problems with her workplace as she was accused by her friend's wife to have an affair with her husband, adding to her stress and depression. She then got drugs from her coworkers and took it as the first attempt for suicide. She was treated for 14 days and went home against medical advice by her mother because she wanted to convert to another religion but her mother was against it. The patient confined herself and quit from her job whenever she experienced extreme sadness.

From 2016 until 2020 she met another guy and eventually got married. She got pregnant in this second marriage and have to stop her bipolar treatment during the pregnancy. At 28 weeks of pregnancy, her symptoms got worse and she was hospitalized at dr. Hasan Sadikin Hospital Bandung, Indonesia, and gave birth through caesarean section in the same hospital as her baby was premature. After giving birth, she experienced baby blues, which was partly caused by her husband divorcing her after giving birth. She left her daughter with her mother and moved to another city to heal. She also adopted some high-risk behaviors, which was getting worse, such as smoking, taking drugs, drunk, engaging in sexual relationships with her friends, and having affairs with her workmates who worked together in a television station. She was then sent for rehabilitation and inpatient treatment in Cisarua, Bogor in early

2022.

This patient is the second child of three children and was born in 1996 in one of the hospitals in West Java through cesarean section based on the indication of fetal distress.

She lived with her child, her mother, and an 18-year-old brother in Cimahi. Her father passed away when she was 6 years old and was a lecturer in one of the universities in Bandung whe he was alive. Her mother worked as a secretary in an insurance company.

She has a family history of mental disorders with her mother's aunt as the kin who also experienced mental disorders. Her mother always support her, especially when she is sick. However, she is a very strict parent and has an ambition that her children, especially the patient, must become successful in career and even dreams that she should become a doctor. She does not allow her children to smoke and was furious when she caught the patient smoking one day. Eventually the mother gets tired of her child's illness. At first, the patient and her brother had a good relationship but when her brother got older, he becomes annoyed by her as he tought she is very talkative and it annoys him. One of the reasons why the patient's mother allowed the patient to be hospitalized during the period of this study was to keep her away from her brother who was taking an exam in the same month.

On her first day of hospitalization in Dustira Hospital, the patient's physical examination, internal status, and neurological status were within normal limits. On the psychiatric examination, she had normal appearance; clear awareness; good orientation to time, place, and people; good abstract thinking ability; no memory impairment; and had good intelligence for her education level. The patient's mood was manic and had a history of irritable inappropriate affect. Non-realistic logical thought with a flight of ideas and logorrhea was identified. No hallucinations or illusions were observed and patient had difficulty initiating and maintaining sleep. The patient's experienced psychomotor improvement during the examination and the patient's understanding of the disease was sixth-degree insight.

The patient's multiaxial diagnosis was Axis I: Bipolar Affective Disorder, Manic, With Psychotic Symptoms (F31.1); Axis II: Borderline Personality Disorder; Axis III: No diagnosis; Axis IV: Problems with the primary support group; and Axis V: GAF 60-51. The initial diagnostics were performed, which included complete blood count with differential, electrolytes level, renal function test, liver function tests, thyroid function test, lipid profile, and Vitamin D, Vitamin B12, and fasting glucose level. Patient also underwent brain computed tomography (CT) and magnetic resonance examination. All results for these tests were all within the normal range and the imaging showed no significant findings.

The patient received various therapies comprising of psychotherapy, psychoeducation, and pharmacotherapy in the form of quetiapine 200mg b.i.d, aripiprazole 10mg q.d., lorazepam 10mg q.d. in the evening, and valproate acid 500mg b.i.d. but she was still talkative, overfamiliar, and overdemanding to other people, especially to her mother. She also had Electroconvulsive Therapy (ECT) at Dr. Kariadi General Hospital Semarang in 2017 and was improved.

On the fifth day of hospitalization, the patient reported marked improvement frm her manic symptom. She could control her emotion. The patient expressed a desire to continue treatment with a psychiatrist and therapist on an outpatient basis.

DISCUSSION

Bipolar disorder (BD), also known as a manic depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity, and the ability to

perform day-to-day tasks. In Indonesia, the BD classification is based on the International Statistical Classification of Disease and Related Health Problems 10th Revision (ICD-10) and *Pedoman Penggolongan dan Diagnosis Gangguan Jiwa (PPDGJ) III*. Patients with this disorder experience an increase in thought, activities, and behavior (mania), which is then alternately replaced by a decreased effect and diminished energy and activity (depression). The diagnosis of the manic phase of the bipolar disorder is confirmed when the patient experience at least four of the following symptoms: increased activities or physical restlessness, talking more than usual or an urge to talk continuously, inflated sense of self-worth, reduced need for sleep, easily distracted, and excessive involvement in activities. What is different about this disorder compared to other mental disorders is that the patient can perfectly heal after every episode. Manic episodes usually occur unexpectedly and last as short as two weeks to five months, which is unlike depression, that tends to last longer.

Manic episodes consist of 3 levels of severity: (1) hypomanic, (2) manic with psychotic symptoms, and (3) manic without psychotic symptoms. An example of a hypomanic disorder is when a woman is in love with a man. In this situation, the woman will feel very happy and excited to do any activities, and she will also experience increased sexual arousal. The hypomanic episode is more controllable than the manic because the symptoms do not deviate from the society's norms. The symptoms in the manic phase are very severe because patients experience chaotic social activities, motor hyperactivity that makes them work beyond ability/ reasonableness which is sometimes unproductive, excessive excitement, talking a lot, and delusions of grandeur. An example of a manic disorder is being overly optimistic at work, as well as feelings of irritability during discussions. The definition of delusions of grandeur is behavior that is in accordance with delusional desires, not systematic, and usually deviates from the norms that exist in the society. If these symptoms then develop further into delusions, a diagnosis of psychotic symptoms should be made.[6]

In the patient in this case study, there are main symptoms and four other symptoms of increased affective state or irritability, increased activities, increased talkactiveness, jumping ideas, and reduced need for sleep. These symptoms have lasted for a month. Thus, the diagnosis of bipolar, manic episodes without psychotic symptoms can be made.

The etiology of BD is not known with certainty. It can occur due to various factors such as genetics and psychosocial factors. Genetic factors are considered as having interdependent gene mechanisms. Family studies demonstrated that BD runs in the family, with a 10–15% risk of mood disorder.[16] Also, activities in daily life in the surrounding environment are the psychosocial factors that usually precede the initial episode of BD. These episodes very often occur after a stressful or traumatic life events. There are 10-12% of cases of bipolar mental disorder that get worse after taking drugs.

This patient has both factors as she has the genetic factors from her mother's side of the family with a history of a family member who experienced a severe mental disorder that she needed to be treated as an inpatient for the rest of her life. The patient also experienced past trauma triggered by the death of her father that makes her feel that she has lost a father figure. She started working in the entertainment field at a young age. The trauma and unstable mood made her fall into having sex with multiple partners and illicit drug use that are worsened by her work environment. Overall, these become one of the psychosocial factors affecting the patient's condition.

It is widely known that there are factors that further worsen the prognosis of bipolar disorder, such as poverty, poor

employment, abuse of alcohol and alcohol consumption, psychotic symptoms, and long-standing depression. The prognosis will be better in patients with manic episode, when there is no desire to end life and with no or minimal psychotic symptoms. Patients with advanced age will also have better prognosis when they have no serious problems with their physical health.

This patient comes from a family with a stable economy and can support her treatment. Symptoms have appeared from a young age and she has a habit of smoking, consuming alcohol, and taking drugs. Thus, the prognosis in this patient is worse.

Antipsychotic treatment is preferable in bipolar patients with psychomotor agitation. Hence, this patient was given the atypical antipsychotic quetiapine and aripiprazole to treat hyperactivity, impulsivity, irritability, and flight of ideas.

CONCLUSION

In people with BD, the mood is unstable and hyperactive with alternating mood between excessively sad and, at other times, extremely happy. The types of treatment given depend on the symptoms experienced, such as the presence of psychotic symptoms, aggression, agitation, and sleep disturbances. Typical antipsychotic drugs are increasingly being used for acute manic episodes and as mood stabilizers. This patient received atypical antipsychotic drugs, because the atypical antipsychotics can reduce positive and negative symptoms. Since this patient also requires long-term treatment and atypical antipsychotic has minimal side effects on extrapyramidal syndrome than typical antipsychotics, this becomes the treatment of choice for her. In some other cases, in order to provide a realistic treatment, it is necessary to consider the patient's background, family conditions, work, social environment, etc. The prognosis for patients with bipolar disorder with manic and depressive episodes is worse than for patients with major depression. In this case, a lot of factors suggest a worse prognosis of the patient's bipolar disorder, such as possible genetic factors; inconsistency in upbringing; the high-tension situation in the family and environment; traumatic events; comorbidity with personality disorder; alcohol and drug abuse; psychotic features; impairment of occupational functioning; and treatment non-adherence. There is a lack of factors suggesting a better prognosis, such as later age of onset, shorter duration of manic phases, and an appropriate treatment, including a combination of medication and psychotherapy.

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DECLARATION OF INTERESTS

The authors declare no conflict of interest.

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