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The Dilemma of Comorbidity: Borderlands between Bipolarity and Conversion

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Abstract
In this case report, we discuss a case with overlapping features of mania and conversion disorder and discuss the diagnostic dilemma.30yr old married woman, pre-morbidly argumentative and sensitive to criticism, was brought with complaints of episodic altered behaviour for 2 months, in form of physical aggression, episodes of singing and dancing at inappropriate times, proclaiming to be God, with sudden episodes of unresponsiveness, reduced sleep and appetite. Past history of similar illness 3 years ago, with poor treatment compliance. No depressive symptoms during course of illness. MSE: pt not communicative; not cooperative with Placid facial expression; closes her eyes tightly and refuses to open even against efforts. Management: T. Olanzapine 5mg was started, considering her aggression and manic symptoms. Throughout her hospital stay, aggression/ altered behaviour was not observed. With the suggestion of discharge only on grounds of improvement, she was noticed to have change in prior behaviour in form of better communication with family members.
Our case attempts to explore the overlap between Bipolar disorder and dissociative disorder with points in favour of both, necessitating a current symptomatic approach and better understanding of the comorbid interface.

Introduction

Comorbidities are a rule rather than an exception in psychiatry. There have been a few studies testing the indistinct boundaries between bipolar disorder and its co-morbidities[(1,2)]

Similarly studies assessing the relation of dissociative disorder with depressive and anxiety disorder are ample[(3,4)]. However, there are only a very few studies and case reports on the association between bipolar disorder, in mania with dissociative disorder[(5–7)]. Here we report a case which presented with overlapping features mania and dissociative (conversion) disorder and discuss the diagnostic dilemma and further management plan.

Case Report

30 yr old married woman, pre-morbidly argumentative and sensitive to criticism, was brought with complaints of episodic altered behaviour for 2 months, in form of physical aggression, episodes of singing and dancing at inappropriate times, proclaiming to be God, with sudden episodes of unresponsiveness, reduced sleep and appetite.

3 years ago, there was similar history of episodes of increased talk, over familiarity, dancing, singing, blessing people saying that she was god, which warranted admission. This admission also had episodes of reported unresponsiveness during hospital stay. All symptoms had gradually improved with T Lithium (900mg), T RSPN (4mg), T THP (4mg). She was reported to have improved 70 – 80% with medications. However there was poor adherence to treatment and patient has been off medication for the past 1 year.

There was NO h/s/o depressive symptoms anytime during the course of illness.

No significant IP issues was reported by the informants. Pt was not cooperative for interview.

O/E: vitals stable, GC – fair

MSE

Pt was not communicative/ not co-oporative with Placid facial expression.

ETEC – occasionally established & not maintained.

For most parts of the interview, she closed her eyes tightly and refused to open her eyes even against efforts by the examiner.

Obeyed oral commands to move her limbs passively and actively on persuasion.

Occasionally responded to a few neutral questions by head movements and gestures and showed no emotional response when talking to her relatives.

Management

Patient was admitted after discussion with her relatives. She was started on T. Olanzapine 5 mg, keeping in mind her aggression and manic symptoms. Though, throughout her hospital stay, there were no episodes of aggression/ altered behaviour observed, she was never amenable for a detailed interview & MSE or assessments.

On the 3rd day of admission, after the treating team proposed discharge only on the grounds of improvement in patient, she was noticed to have change in prior behaviour in form of better communication with family members. Though mood was reported to be fine, Affect still remained blunted with restricted range and reactivity.

No thought / perceptual abnormality was noted.

On Follow up: On regular medications**,** husband reports patient to have improved completely with no h/o any abnormal behaviour and functioning well at home.

Areas of Clinical Dilemma

BIPOLAR DISORDER	**CONVERSION DISORDER**
COURSE OF ILLNESS: Episodic illness SYMPTOMS: • Increased talk, overfamiliarity, inappropriate spontaneous episodes of singing, dancing, grandiose talk. • no evident secondary gain could be established PAST HISTORY: Similar episode 3yrs ago with significant improvement with mood stabilizers and antipsychotics.	COURSE: Episodic • drastic improvement in MSE noticed on proposed discharge. • complete remission reported on follow-up. SYMPTOMS: • episodes of unresponsiveness • absence of any manic symptoms throughout hospital stay, despite presentation at home just before hospital visit(as per informants). PMP: stubborn, sensitive to criticism, argumentative, demanding

Discussion

Comorbidities are as common as 60% in cases of bipolar affective disorder in the form of substance use, borderline personality disorder, anxiety, conduct disorder and attention deficit hyperactivity disorder[1,2,8] Dissociative experiences are considered to be disintegration of the usually integrated function of consciousness, memory, identity and perception of one's environment or to be a coping mechanism to deal with unbearable stressful situation[9] Being a common disorder in the Indian subcontinent, various studies and case reports have been published on the association of dissociative (conversion) disorder with anxiety and depressive disorders[3,4] The presence of dissociative symptoms during the depressive episode of bipolar depression have been reported in literature. Also studies have reported dissociative episodes as a differentiating factor between bipolar depression and unipolar depression[10] However, one case of co-morbid hypomania with dissociation and panic disorder has been reported by pradhan et al[5] followed by a few case reports on association of dissociative (conversion) episodes and mania elucidating the various facets interlinking the two disorders[6,7] which is similar to our case under consideration. The neurobiological basis of the relation still remains perplexing, while it is suggested to be due to an underlying disturbance in anterior cingulate cortex (ACC)[11] dorsomedial prefrontal cortex (MdPFC)[12] and insular cortex (IC)[13] which is found to be common in both the disorder. Hence, dissociation and bipolar disorder, both being associated with early childhood trauma, anxiety symptoms as well as neurobiological underpinnings involving amygdala and other limbic structures in functional imaging, demand further heuristic exploration for any furthur underlying relations between the two[14]

In view of the substantial overlap between symptoms of BPAD and dissociative (conversion) disorder, an accurate cross-sectional assessment is inevitably difficult to achieve. Considering the inherent challenge in interviewing a bipolar patient, especially one with co-morbidities, the corraboration with family member for accurate history is of utmost importance for diagnosis. A careful longitudinal assessment that establishes a chronology of onset of different conditions, a symptom and functional profile between mood episodes, the course of illness, and response to treatment are essential for a more robust diagnosis.[15]

Though the clinical guidelines for management of Bipolar disorder is passable, most have limited recommendations specific to the patient with comorbidities, reflecting the limited nature of clinical evidence in this arena.[16,17]

Conclusion

Hence, our case also crosses the borderlands between Bipolar disorder and dissociative disorder with points in favour of both necessitating a current symptomatic approach and a more rigorous follow up. In conclusion, the recent advances made in the field of neurobiology of bipolar and affective disorders, pave way for more research in refining our understanding of the co-morbid interface of BPAD and dissociative disorders.

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