Current PSYCHIATRY

CASES THAT TEST YOUR SKILLS

Matthew's rapid swings from psychosis to euphoria, depression, and rage defy diagnosis. The challenge: help this brilliant teen survive high school and reach his potential.

Why me? One youth's quest for sanity

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HISTORY THREE DIAGNOSES BY AGE 15

Matthew, age 17, has been hospitalized twice for psychiatric treatment. At school, he has no friends, is extremely energetic and volatile, and has paranoid delusional thoughts. At night, he becomes depressed over his inability to "fit in."

Brilliant and deeply spiritual, Matthew obsesses over sins he believes he committed, yet he is angry with God over his illness, its impact on his life, and his apparently dimmed prospects for the future.

His troubles started early. While in preschool, a teacher said he had "autistic tendencies." He was shy and larger than most children (>90th percentile in height and weight). He acquired language slowly, beginning at 18 months, and slept poorly, waking several times nightly.

Throughout grade school, Matthew was both bright and eccentric. His Wechsler Intelligence Scale for Children-III scores, taken at age 9, were 133 (full scale), 143 (verbal), and 111 (performance). By the third grade, he struggled with the meaning of the universe and other existential issues. In sixth grade, he believed his mouth stank and frequently used mouthwash, even at school. He also had periods of excessive hand-washing.

In fifth grade, a pediatrician diagnosed Matthew as having attention-deficit/hyperactivity disorder after his teacher complained about his behavior in class (blurting out answers, correcting the teacher, restlessness, questioning authority). The doctor prescribed methylphenidate and dextroamphetamine, but the combination made Matthew feel both "drugged and wired." He stopped taking the agents after 8 weeks.

At age 15, Matthew saw a psychiatrist. His parents said he was depressed and obsessively afraid of being abandoned. Every day, they said, he kissed both parents twice on each cheek.

The psychiatrist diagnosed Matthew with obsessive-compulsive disorder. A trial of paroxetine, 20 mg/d, caused mild irritability with no symptom improvement. After 2 months, Matthew was switched to fluoxetine, initially 10 mg/d and increased to 20 mg/d, but after 6 weeks he suffered an acute manic episode. He claimed he was one with the universe and reported auditory hallucinations, intense suicidal thoughts, and sleeplessness for days on end.

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Matthew was hospitalized for 7 days. Haloperidol, dosage unknown, decreased his psychosis but did not return him to baseline. The psychiatrist stopped fluoxetine because Matthew's parents feared the antidepressant was causing his suicidality. No other agent was tried at this time.

Matthew's symptoms suggested:

- **bipolar disorder**
- **schizophrenia**
- **schizophreniform disorder**
- **major depression with psychotic features**

The authors' observations

Soon after Matthew began taking fluoxetine for apparent OCD and depressive symptoms, profound psychotic symptoms surfaced. These included command hallucinations, delusions, disordered and disorganized thought, high suicidality, motoric hyperarousal, and marked anxiety.

Although positive schizophrenia symptoms were predominant, mood and affect instability were also pronounced. The admitting psychiatrist diagnosed Matthew with schizoaffective disorder but did not include in the record the basis for this diagnosis.

Matthew's OCD symptoms did not appear to derive from a delusional system or impaired reality testing. These symptoms were often associated with guilt and were consistent with other excessive behaviors.

HOSPITALIZATION NEW DIAGNOSIS

Out of the hospital, Matthew's ability to function declined over several months and he began to look disheveled and dirty. He was acutely suicidal, excessively guilty, isolative, and slept 1 to 2 hours nightly.

How would you have handled this case?

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Matthew was again hospitalized, this time for 2 months. The psychiatrist revised the diagnosis to schizoaffective disorder, bipolar type, based on Matthew's psychotic episodes, emerging positive symptoms, social withdrawal, and family history. (A male maternal cousin has paranoid schizophrenia.)

Risperidone, initially 0.5 mg nightly and titrated to 0.5 mg each morning and 1.5 mg nightly, gradually improved Matthew's psychotic symptoms. The psychiatrist added divalproex, 250 mg bid titrated to 250 mg each morning, 250 mg at noon and 500 mg nightly, to address Matthew's affective lability. After another 2 months of partial hospitalization, he was discharged. Thought disorder symptoms persisted, but reality testing was intact.

Back in high school, Matthew has gotten into a screaming match with the principal and heated political arguments with his teachers. He shows bursts of energy, agitation, and euphoria and is at times overdramatic and grandiose. His rapid-fire creativity easily shifts to irritability and paranoid delusional thinking punctuated by rage.

Almost nightly, Matthew sinks into depression. He also compulsively washes his hands, binge eats, has difficulty reading social cues and making conversation, and believes he is a "misfit." He views Internet pornography to relieve sexual obsessions, but this habit leads to guilt-ridden ruminations that trigger suicidal thoughts.

For Matthew, high school's pattern of alternating regimentation and intellectual stimulation constantly provokes mania. He sometimes disguises these episodes by playing "class clown," only to sink into despair at night over his dyscontrol. His

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Table 1

Why psychoeducation can help patients with bipolar disorder

1. **50% of patients** have frequent recurrences despite treatment
2. **40%** do not adhere to treatment, often because of lack of insight
3. **Mood and coping improve** among patients receiving family-focused psychotherapy and family psychoeducation
4. **CBT combined with psychoeducation** leads to:
   - fewer relapses
   - longer time between relapses
   - fewer hospitalizations
   - improved function
   - improved treatment compliance
   - reduced depressive, manic, and mixed symptoms

Source: Adapted from references 2, 5.

desperation causes frequent anxiety attacks. Searching for answers, Matthew changes psychiatrists and turns to us for help.

At this stage, you would address Matthew's:

- **obsessive-compulsive symptoms**
- **mood swings**
- **depressive symptoms**

The authors' observations

Matthew's positive symptoms, bipolar presentation, and the severity and duration of his psychotic episodes supported the schizoaffective disorder diagnosis,[1] yet his cardinal type I bipolar disorder features were striking. His severe thought disorder and perceptual distortions improved, but rapid cycles between euphoria, rage, and depression persisted, as did shifts from hypersomnia to insomnia.

Matthew's lack of negative symptoms prompted me (Dr. Lundt) to rethink the diagnosis. Though isolated from peers, Matthew remained affable throughout treatment and was emotionally attached to his parents and treating psychiatrist. He rarely appeared flat or blunted and showed no hostility or other signs of resistance typical of a patient with schizophrenia. He cooperated with treatment and showed insight into his illness, even at the height of his acute psychosis. His language was never significantly disorganized but his depression and obsessive guilt were chronic, dominant, and treatment-resistant. I learn over time that Matthew finds certain events highly stressful, and these exacerbate his psychotic features.

Matthew's diagnosis—and how to address it—came down to two issues:

- Treatment would be similar for schizoaffective disorder or type I bipolar disorder with severe psychotic features.
- Matthew viewed schizoaffective disorder as a life sentence of insanity. Changing the diagnosis to type I bipolar disorder would allow him and his family to see a more manageable and hopeful prognosis.

Matthew grapples with typical adolescence issues: identity, peer relationships, social pressure, body image, and insecurity. Because he lacks the coping skills to navigate to adulthood, his depression and mood instability are clinical priorities.

In managing Matthew's care, I refer him to a psychologist (Dr. Brownsmith) whose psychotherapeutic approach will depart significantly from traditional medical-model psychotherapy. Because bipolar and psychotic symptoms have stalled Matthew's development, the psychologist will combine cognitive-behavioral therapy (CBT) with psychoeducation that emphasizes skills acquisi-

tion and coping techniques (*Table 1*). The goal is to convince Matthew that he can learn to manage his life.[2]

TREATMENT TEAM MEETINGS

Matthew begins individual psychotherapy with periodic family therapy and continued medication. Risperidone, 0.5 mg each morning and 1.5 mg nightly, and divalproex, 500 mg bid, have minimized Matthew's psychosis and stabilized his mood but caused a 45-lb weight gain across 6 months. Matthew alternately joined professional weight-loss programs and worked with a personal trainer to stabilize his weight.

Because day-to-day intervention is critical to keeping Matthew's anger from derailing his progress, we meet regularly—sometimes weekly—with him, his parents, and his school social worker to plan treatment and provide psychoeducation *(Table 2)*.[3]

Throughout his senior year, Matthew's sexual obsessions cause severe guilt, and he begs to be "chemically castrated." Clomipramine, started at 25 mg nightly and titrated to 300 mg nightly over 2 years, diminishes his obsessions. ECGs are performed and clomipramine plasma levels are checked quarterly to guard against cardiotoxicity. Risperidone is continued and divalproex is gradually increased to 1,000 mg bid, ultimately reaching valproic acid levels of 79 µg/mL.

Through our therapeutic alliance and the change in diagnosis, we help Matthew gradually overcome his initial anger, resistance, despair, and suicidality. Drawing from research data while offering emotional support, we engage Matthew in a team therapy approach.

Matthew acknowledges his grief and anger at having a severe mental illness and agrees to learn to regulate his moods and participate in CBT. Responding with humor to his rapid-fire, manic discussions and animation helps solidify the alliance. We stay highly involved with his parents, often responding to their after-hours phone calls.

Table 2

Keys to successful psychotherapy for bipolar disorder

- **Build** a strong treatment team and therapeutic alliance
- **Educate** patient on skills, stress vulnerability
- **Enhance** treatment compliance with frequent appointments, psychoeducation, and family involvement
- **Induce** a routine, such as by having patient write out a schedule or buy a day planner
- **Perform** CBT to decrease automatic depressive thoughts
- **Teach** patient to recognize and control prodromal manic symptoms
- **Suggest** behavioral techniques to reduce environmental stress, promote social adaptation
- **Promote** cognitive restructuring to help patient cope with thought disorder
- **Teach** coping strategies to enhance behavioral control
- **Monitor** high-risk situations, behaviors, and symptoms
- **Teach** internal and external coping mechanisms to prevent relapse

CBT: Cognitive-behavioral therapy

After approximately 9 months of CBT, Matthew sees his disordered thoughts and perceived loss of control as symptoms to be overcome.[4] He adapts some of his fantasy life to replace his obsessive fear and anger. He develops highly creative, embellished visual imagery of a "safe place" in which he feels nurtured and protected. This imagery, coupled with relaxation exercises, is audiotaped so that he can practice at home.[5] Psychoeducation and problem-solving help him dress appropriately and improve his hygiene.

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Matthew's intelligence and social awareness underlie strongly held values and opinions that fuel his anger. Media coverage of politicians, political debates in school, extreme religious views, and judgmental statements about sexuality frequently provoke rage. (Matthew once battered a street preacher who was decrying homosexuality.) By acquiring anger management strategies, he learns to avoid potentially volatile situations.[6]

Frequent crisis intervention keeps Matthew stable, while family therapy helps him follow his psychologist's plan to maintain medication adherence and manage his circadian rhythms, activities of daily living, and CBT. His parents prompt him to use therapeutic techniques, support him during crises, and make sure he has the structure and support to participate in treatment, school, and social activities.[7]

Thanks to this team effort, Matthew graduates high school and is accepted at a small coastal college 1,500 miles from home.

How would you manage Matthew's transition to college?

- **refer him to on-campus specialists**
- **recommend a college closer to home**
- **identify and work with outside specialists near the campus**

The authors' observations

We continue to work with Matthew's parents to help him handle college life. His parents identify prospective mental health professionals near the college; we interview them and provide Matthew's history and treatment information. We communicate during school holidays, home visits, and by phone as needed with Matthew, his new therapist and psychiatrist, and his parents.

CONTINUED TREATMENT THE 'AWAY TEAM'

Together, Matthew's home- and college-based treatment teams ensure treatment continuity. During school breaks, Matthew's "home team" continues medication management and psychotherapy. Thanks to such persistent monitoring, Matthew finishes college in 4 years.

Medications and careless eating habits, however, have taken a severe metabolic toll. To help Matthew confront the added pressures of college, risperidone was gradually increased to 1 mg bid, divalproex to 1,000 mg each morning and 1,500 mg nightly, and clomipramine to 350 mg/d. By graduation day, he weighs 330 lbs with a body mass index of 40 kg^2. His triglycerides have more than doubled (141 mg/dL before college, 307 mg/dL after), and he has developed hypothyroidism. Total cholesterol is 247 mg/dL. His family doctor prescribes thyroid supplementation and atorvastatin, titrated to 40 mg/d.

To stem Matthew's weight gain, we taper him off divalproex and switch him to topiramate, 100 mg nightly, but topiramate alone does not control his mood. Subsequent trials of quetiapine, 200 mg nightly, olanzapine, 20 mg nightly, and ziprasidone, 80 mg bid, are ineffective.

To control Matthew's mood and weight, you would:

- **try an anticonvulsant**
- **try another antipsychotic**
- **restart topiramate with thyroid/lipid therapy**

The authors' observations

Matthew's problem is common. He responded well to risperidone and divalproex, but these agents contributed to significant weight gain. Topiramate augmentation and trials of other atypical antipsychotics

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were unsuccessful. The atypical antipsychotic aripiprazole or anticonvulsant lamotrigine might have stabilized Matthew's mood and weight, but these drugs were not available while he was in college. Dietary interventions were tried but are difficult to enforce on a college student living away from home.

CONCLUSION A LEARNING EXPERIENCE

We stop divalproex and restart topiramate, 200 mg nightly. Matthew continues to take risperidone, 2 mg each morning and 5 mg at night; clomipramine, 150 mg each morning; thyroid supplementation, 0.2 mg/d; and atorvastatin, 40 mg/d. He loses 10 lbs over 3 months; his weight eventually drops to 290 lbs and remains stable.

Matthew enters another university to pursue a master's degree. He shifts to a new college-based mental health team and moves into an apartment.

There are setbacks. Missed therapy appointments cause treatment lapses, and a teaching assistantship leads to problems managing schoolwork. Working with Matthew's treatment team and his parents, we intervene to resolve crises, re-establish treatment, and help him resolve issues of identity, confidence, coping, and routine. With this persistent follow-up, he earns his master's degree.

Now age 26, Matthew is pursuing a doctorate. He is taking more responsibility for his appointments and medication and is undertaking bill-paying and travel arrangements. With ongoing psychotherapy and mediation, Matthew regulates his mood and is learning to recognize prodromal symptoms and anticipate stress.[8] He is more comfortable in social settings and has some friends and study partners, although he continues to deeply ponder philosophical and spiritual issues.

Related resources

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- Bipolar focus (information, chat room for families and patients). www.moodswing.org.

DRUG BRAND NAMES

Atorvastatin • Lipitor
Clomipramine • Anafranil
Dextroamphetamine • Dexedrine
Divalproex • Depakote
Fluoxetine • Prozac
Methylphenidate • Concerta, Ritalin
Olanzapine • Zyprexa
Paroxetine • Paxil
Quetiapine • Seroquel
Risperidone • Risperdal
Topiramate • Topamax
Ziprasidone • Geodon

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Bottom Line

When differentiating pediatric bipolar disorder from schizophrenia, signs of emotional attachment and absence of negative symptoms can help rule out schizophrenia. A strong therapeutic alliance, combined with psychotherapy that includes cognitive-behavioral therapy and psychoeducation, can help youths manage bipolar symptoms