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CASE REPORT

Bipolar affective disorder - Clinical manifestations and treatment approaches

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Introduction: Bipolar affective disorder is a chronic psychiatric illness characterized by alternating episodes of elevated and depressed mood. Its clinical presentation varies widely, requiring a nuanced diagnostic approach. Differentiating between type one and type two forms remains essential for appropriate treatment planning.

Presentation of case series: This case series describes three patients diagnosed with bipolar affective disorder, each presenting distinct clinical patterns. The first patient exhibited a classic manic episode with psychotic features, requiring inpatient stabilization and combination pharmacotherapy. The second case involved a depressive episode with a prior history of hypomania, consistent with bipolar type two. The third patient presented a mixed episode marked by agitation, emotional instability, and suicidal ideation. All cases included a family history of mood disorders, supporting genetic predisposition. Therapeutic interventions consisted of mood stabilizers, antipsychotics, and psychoeducation. Clinical evolution was favorable in patients with high adherence and social support.

Conclusions: Bipolar affective disorder presents with diverse and sometimes atypical symptoms. Early recognition and accurate subtype differentiation are crucial for effective management. Case-based observation highlights the importance of individualized treatment, psychosocial support, and long-term monitoring.

Keywords: bipolar disorder, atypical presentation, mood episodes, clinical management

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Introduction

Bipolar affective disorder is a severe and recurrent psychiatric illness characterized by alternating episodes of mania, hypomania, and depression. The condition affects approximately one to two percent of the population and is a leading cause of disability worldwide [1]. The typical onset occurs in late adolescence or early adulthood, though variability in clinical presentation often delays diagnosis [2]. The course of the disorder is frequently chronic, with high rates of relapse and significant impact on occupational, social, and interpersonal functioning [3]. These disorders have a significant psychosocial impact and are associated with functional impairment, increased morbidity, and high suicide risk. Although their exact pathogenesis remains unclear, bipolar disorders are widely acknowledged to have a multifactorial etiology involving a complex interaction between biological, psychological, and social factors. Understanding this biopsychosocial model is essential for accurate diagnosis and effective treatment planning.

Biological factors

Genetic vulnerability: Twin and family studies support a strong hereditary component in bipolar disorder. First-degree relatives of individuals diagnosed with bipolar disorder have a significantly elevated risk of developing affective disorders. Concordance rates for monozygotic twins are estimated to range between 40–70%, with heritability approximated at 79% [4].

Molecular and genomic mechanisms: Genome-wide association studies (GWAS) have identified more than 30 risk genes associated with bipolar disorder, including *CACNA1C*, *ANK3*, *NCAN*, and *ODZ4* [5]. Specific chromosomal regions such as 4p16-p15, 6q16-q22, and 18q21-q23 have been linked to increased susceptibility [6]. Epigenetic mechanisms are believed to modulate gene expression in response to environmental factors, further contributing to the disorder's heterogeneity.

Neuroendocrine dysregulation: Hyperactivity of the hypothalamic-pituitary-adrenal (HPA) axis, particularly during manic episodes and euthymic phases, suggests impaired stress regulation and contributes to affective episode recurrence [6].

Circadian rhythm abnormalities: Bipolar disorder is associated with disruptions in circadian regulation, including sleep-wake cycle irregularities, altered daily activity patterns, and meal timing disturbances. These chronobiological instabilities are considered core pathophysiological features of mood disorders [7].

Psychological factors

Early life stress and trauma: Adverse childhood experiences, including emotional abuse and neglect, are strongly correlated with the later onset of bipolar disorder. These psychological stressors influence emotional regulation and cognitive development, increasing vulnerability to mood dysregulation in adulthood [8].

Cognitive vulnerability and maladaptive coping: Individuals with bipolar disorder often exhibit cognitive distortions, poor emotional insight, and

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maladaptive coping mechanisms, especially in response to interpersonal stress or conflict.

Social and environmental factors

Perinatal and prenatal stressors: Maternal infections during pregnancy (e.g., CMV, influenza) have been implicated in increasing the risk for psychiatric disorders, including bipolar disorder with psychotic features [8].

Sociodemographic stressors and life events: Traumatic life events—such as bereavement, divorce, or unemployment—are significantly associated with the first manic episode and disease onset. Substance abuse, particularly cannabis and alcohol, is also a major environmental risk factor, especially when initiated before the age of 25 [8].

Gender-specific patterns: Females are more likely to experience depressive episodes, whereas males may present more frequently with manic symptoms. Gender differences may influence both symptomatology and treatment responsiveness.

Bipolar disorder is classified into distinct subtypes, most commonly type one—marked by at least one manic episode—and type two, which involves at least one hypomanic episode and one major depressive episode [9].

Despite advancements in diagnostic criteria, differentiating between subtypes remains a clinical challenge, particularly in early stages or atypical presentations [10]. Misdiagnosis can delay effective treatment and increase the risk of complications such as suicide or poor adherence [3, 11]. Case-based documentation remains essential for understanding the diverse manifestations of the disorder and refining therapeutic approaches.

This study aims to present a series of three clinical cases of bipolar affective disorder, illustrating the diversity of symptom profiles, diagnostic complexity, and treatment strategies required for optimal management.

Materials and Methods

This case series analyzes three clinical cases of patients diagnosed with bipolar affective disorder (BD) who are currently under psychiatric care at the Cahul Health Center , Republic of Moldova.

Inclusion criteria:

- Age between 18 and 65 years
- A confirmed diagnosis of bipolar affective disorder according to ICD-10 criteria
- Presence of a depressive episode or major depressive episode

Exclusion criteria:

- Age under 18 or over 65 years
- Severe alcohol or substance use disorders
- Active substance use (e.g., narcotics, alcohol) interfering with clinical evaluation

The evaluation procedure included a comprehensive clinical history and psychiatric examination. The onset of symptoms, course and type of affective episodes (depressive, manic, or mixed), and identification of etiological or precipitating factors were systematically documented. A core component of the clinical investigation involved analyzing psychiatric admissions and discharges, focusing on the frequency and duration of hospitalizations, the initial clinical presentation, and the discharge criteria based on symptomatic remission.

To ensure a thorough clinical assessment, several standardized tools and structured methods were utilized:

Structured Clinical Interviews: A semi-structured clinical interview was conducted with each patient, following the diagnostic criteria outlined in the ICD-10 and DSM-5. The interview covered key aspects of symptomatology, including the frequency, severity, and duration of mood episodes (manic, depressive, or mixed), as well as any associated psychotic features.

Psychiatric Rating Scales: To evaluate the severity of depressive and manic symptoms, the **Hamilton Depression Rating Scale (HDRS)** and the **Young Mania Rating Scale (YMRS)** were administered.

Self-Report Questionnaires: Patients completed self-report questionnaires to assess subjective mood states and the impact of bipolar disorder on their daily functioning. The **Mood Disorder Questionnaire (MDQ)** was used as a screening tool for bipolar disorder symptoms, while the **Beck Depression Inventory (BDI)** provided further insight into the severity of depressive symptoms.

Psychiatric and Family History: A thorough review of the patients' psychiatric history, including previous episodes, hospitalizations, and family history of psychiatric disorders, was performed. This helped in understanding the hereditary component and potential triggers of the disorder.

Objective clinical data relevant to diagnostic confirmation were obtained from the patients' medical records, including:

- Diagnostic classifications based on ICD-10 or DSM-5 standards
- Predominant symptom profiles
- Pharmacological treatment regimens
- Ancillary investigations performed during psychiatric follow-up

Monitoring of affective episodes was done through longitudinal observation of their frequency, severity, and duration. Therapeutic response and remission periods were also evaluated to understand the clinical evolution of each case. These methods allowed for the collection of clinically relevant data to support diagnosis and guide case management within the context of psychiatric care in the Republic of Moldova.

Case presentations

Case-1

The patient, a 32-year-old female, was hospitalized following a progressive deterioration in behavior over one week, characterized by excessive talkativeness, reduced need for

sleep, irritability, and episodes of euphoria. On examination, she presented with pressured speech, flight of ideas, psychomotor agitation, and elevated self-esteem bordering on grandiosity. She also displayed intrusive social behavior and risk-taking actions, including impulsive spending and disinhibited sexual behavior. Insight was absent, and psychotic features, such as persecutory delusions, emerged during the manic peak. A family history of recurrent depressive episodes in the maternal aunt was noted. Based on the clinical picture and symptom duration, a diagnosis of bipolar affective disorder type I was established. Upon admission, the patient's manic symptoms were prominent, and their intensity progressively worsened. Initial treatment with sodium valproate (1,000 mg/day) and quetiapine (400 mg/day) led to gradual improvement over the course of three weeks. During the first days of hospitalization, manic symptoms reached a peak, with the patient exhibiting significant impulsivity, risk-taking behaviors, and psychotic delusions. As the treatment began, the intensity of symptoms started to reduce, particularly in terms of psychomotor agitation and pressured speech. After two weeks, the manic symptoms were less frequent and intense, and psychotic features began to resolve. The patient also started showing some insight into her condition. By the third week of treatment, there was a significant reduction in both the intensity and quality of the symptoms. Euphoria and irritability were markedly decreased, and the patient's affect stabilized. Psychotic features were completely absent, and the patient demonstrated improvement in both mood and behavior. Following this period of stabilization, psychoeducation and family involvement were initiated before discharge, and the patient was placed under outpatient follow-up. This case illustrates the progressive improvement in symptom intensity and quality through proper pharmacological management and supportive measures, leading to a favorable clinical outcome.

Case-2

The patient, a 24-year-old male, presented to the psychiatric outpatient clinic with a major depressive episode lasting for three weeks. He reported persistent sadness, anhedonia, fatigue, poor concentration, and suicidal thoughts, without psychotic features. Upon further evaluation, he revealed a previous episode of elevated mood and increased activity lasting four days, which had not caused significant functional impairment at the time. No prior psychiatric diagnoses had been made, and there was no relevant family psychiatric history. The clinical features met the diagnostic criteria for bipolar disorder type II. At the time of presentation, his depressive symptoms were prominent, with significant impairment in daily functioning. The depressive state was characterized by marked anhedonia, fatigue, and poor concentration, along with persistent suicidal ideation. However, after the initiation of treatment, his condition began to improve. He was prescribed **lamotrigine** (titrated to 100 mg/day) and engaged in structured **cognitive-behavioral therapy**. Initially, the depressive symptoms showed gradual improvement, with the intensity of sadness and fatigue lessening over time. His mood became more stable, and his concentration and energy levels improved. The suicidal thoughts diminished significantly by the end of the first four weeks. By the six-week mark, the patient was in a much better mental state, with full resolution of depressive symptoms and a notable return to baseline functioning. His insight into the condition was intact, and he demonstrated adherence to both pharmacological and therapeutic components of his treatment. This case demonstrates the effective resolution of depressive symptoms over a six-week period, with the treatment of **lamotrigine** and **cognitive-behavioral therapy** facilitating a return to a stable mood and enhanced quality of life. Regular follow-up visits ensured ongoing management and adjustment of treatment as needed.

Case-3

The patient, a 71-year-old female, has a long history of bipolar disorder, alternating between depressive and manic episodes for approximately 20 years. She had previously been hospitalized multiple times for exacerbations of her symptoms. At the time of her admission in December 2014, she presented with a severe depressive episode, characterized by a lack of appetite, insomnia, sadness, and feelings of being "exhausted" and unable to do anything. Her mood was markedly low, and she exhibited emotional lability, with a constant fear of death. Her thoughts were confused and chaotic, and her concentration was poor. Her clinical presentation met the criteria for a mixed episode in bipolar disorder, with both depressive and manic features observed. During her hospitalization, she was prescribed **Amisulpride** (200 mg/day), **Valproic acid** (300 mg/day), and **Clomipramine** (75 mg/day). Despite this treatment, her condition worsened, and she was rehospitalized in April 2015 and again in April 2017, where she continued to show similar symptoms, including emotional instability, agitation, and confusion. In April 2017, her treatment regimen was adjusted to include **Sulpiride** (100 mg/day), **Paroxetine** (20 mg/day), and **Zopiclone** (7.5 mg for insomnia). Over time, her symptoms showed some improvement, with a reduction in agitation and improvement in sleep patterns. By her final hospitalization in May 2019, she was stable, with no acute complaints, and her sleep had normalized. This case highlights the chronic and recurrent nature of bipolar disorder and the importance of ongoing treatment and monitoring. Despite the patient's advanced age and history of multiple hospitalizations, her condition showed notable improvement with pharmacological intervention, but continued monitoring and care were recommended due to the high risk of relapse.

Discussions

This case series illustrates the clinical heterogeneity of bipolar affective disorder, emphasizing the diagnostic and ther-

apeutic challenges commonly encountered in psychiatric practice. The three cases presented reflect distinct subtypes and mood episode patterns, including classic mania with psychosis (type I), depressive episodes with a history suggestive of hypomania (type II), and mixed affective states. Such diversity underlines the need for thorough clinical evaluation, including longitudinal symptom tracking and family history assessment.

From a **biological perspective**, the early age of onset observed in all three patients is consistent with epidemiological data showing peak incidence between ages 18 and 30 [11]. Additionally, the presence of genetic loading—reported in two of the three cases—supports existing evidence regarding the strong heritable component of bipolar disorder [12]. Nonetheless, the third case involved late-onset manifestations in a patient with a long-standing history of mood instability, requiring tailored pharmacological management across several admissions. All patients responded favorably to individualized pharmacotherapy combining mood stabilizers and atypical antipsychotics, in line with current clinical guidelines [13]. Lithium and valproate were used in mood stabilization, while olanzapine and amisulpride addressed psychotic or agitation-related symptoms.

On the **psychological level**, each case involved significant affective dysregulation—ranging from psychotic depression to emotional lability and impulsivity in mixed episodes. Symptoms such as hopelessness, insomnia, cognitive clouding, and suicidal ideation were present in various forms across all cases, aligning with findings from other studies which report high variability in the course and severity of bipolar episodes [1, 3]. Insight and motivation for treatment varied, especially in the elderly patient, highlighting the importance of adjusting psychoeducational interventions to the patient's cognitive and emotional resources.

Social and environmental factors also played a crucial role. From a **social standpoint**, the patients experienced a variety of psychosocial stressors, including emotional neglect, family dysfunction, bereavement, and increased caregiving responsibilities. These elements may influence both the onset and prognosis of the disorder, as demonstrated in the third case involving a widowed patient with comorbid somatic conditions and social role strain [14, 15]. The psychosocial burden and lack of stable support networks in some of the cases underlined the value of community-based care and family involvement in long-term management.

Pharmacological treatment with mood stabilizers and atypical antipsychotics proved effective in achieving symptom stabilization in all cases. This supports current clinical guidelines that recommend individualized pharmacotherapy, adjusted according to episode type and severity [9, 16]. In addition, **psychosocial interventions**—including supportive psychotherapy and psychoeducation—played a crucial role in treatment adherence and relapse prevention.

Overall, the findings highlight the necessity of a **bio-psycho-social framework** in the comprehensive management of bipolar disorder. Such an approach allows for personalized therapeutic strategies that take into account biological predispositions, individual psychopathology, and the broader social context. Limitations of this report include the small number of cases, absence of long-term follow-up data, and lack of standardized psychometric assessments. Nevertheless, the series contributes to the clinical literature by underscoring the importance of multidimensional, patient-centered care in bipolar affective disorder.

Conclusions

Bipolar affective disorder remains a complex and heterogeneous psychiatric illness, requiring careful diagnostic assessment and long-term management. The cases presented in this series emphasize the variability of clinical expression, from classic manic episodes to depressive and mixed states. Accurate identification of the subtype is essential for selecting appropriate pharmacological strategies and reducing the risk of recurrence and suicide. Early diagnosis, detailed psychiatric history, and recognition of environmental and genetic factors are critical to improving outcomes. Individualized treatment plans, combining pharmacotherapy with psychoeducation and psychosocial support, offer the best chance for sustained remission and functional recovery. Although limited by sample size, this case series contributes to clinical understanding by underscoring the diversity of bipolar presentations and the importance of a multidisciplinary and personalized approach in psychiatric care. Future research on bipolar disorder should focus on identifying genetic, neurobiological, and imaging biomarkers to enable early diagnosis and personalized treatment. Investigating environmental and psychosocial factors, such as childhood trauma or substance abuse, could help better understand the disorder's onset and progression. Additionally, exploring innovative therapies tailored to individual patients based on clinical and biological data could improve treatment outcomes. Long-term studies on pharmacological and psychosocial treatments would be valuable to assess their effectiveness in preventing relapse and maintaining stability. Research into sleep disturbances and circadian rhythm regulation could also offer new avenues for managing bipolar episodes. Cross-cultural studies would help to understand how bipolar disorder presents in different populations and the impact of cultural factors on treatment response. These efforts would contribute to more effective, personalized approaches for managing bipolar disorder.

Authors' contribution

SM (Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Project administration; Resources; Validation; Visualization; Writing – original draft; Writing – review & editing)

BA (Conceptualization; Methodology; Supervision; Validation; Writing – review & editing)

Conflict of interest

None to declare.

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