CASE REPORT

Mania Induced by a Low Dose of Citalopram: A Case Report

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Abstract

Background: Antidepressant-induced mania is commonly observed in contemporary clinical practice. The problem in patients with unipolar depression has been evident since the introduction of the first antidepressants. Selective serotonin reuptake inhibitors (SSRIs), as new drugs, are one of those drugs that may lead to treatment-induced mania. The risk of inducing mania in bipolar patients with citalopram is comparable to the documented risk with other SSRIs. This case study elucidates the crucial factors for distinguishing key depressive episodes between bipolar and unipolar depression and provides recommendations regarding the use of antidepressants in high-risk patients.

Case presentation: A 24-year-old Kurdish woman developed mania after self-administering a low dose of Citalopram for depression. Diana Azad (DA) is a 24-year-old single female. She was referred to the Mental Health Treatment Center by the police under a judicial order for psychiatric assessment and treatment. DA was irritable, aggressive, and restless. She showed disruptive behavior, including screaming in the wards and showing her will to leave the hospital. She was diagnosed with bipolar disorder I, a manic episode, and was admitted to the hospital with her mother's companion. Rapid tranquilizers were given at the start, and then mood stabilizers and antipsychotics were prescribed.

Conclusion: We advocate the idea that caution must be taken in treating depression with citalopram in young populations, even in the absence of a family history of affective illness.

Keywords: Antidepressant-induced mania, Bipolar depression, Case report, Citalopram, Selective serotonin uptake inhibitors.

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Introduction

Antidepressant-induced mania\hypomania is a commonly observed phenomenon in patients with bipolar disorder.[1] Numerous studies have consistently reported the potential of antidepressant treatment to trigger mood switching during major depressive episodes.[2,3] This problem has been recognized since the advent of the first antidepressants, particularly in patients with unipolar depression.[4] Notably, a study has indicated that approximately 20–40% of individuals with bipolar disorder may possess inherent susceptibility to antidepressant-induced manias. Given the heightened risk of mood switching, the American Psychiatric Association (APA) guidelines for bipolar disorder treatment in 2002 recommended a more cautious approach toward the use of antidepressants.[5]

Antidepressant-induced mania was observed across all age groups, including adults, adolescents and even children with a higher risk noted in the younger population.[1–3,6–8] Among the newer drug classes, selective serotonin uptake inhibitors (SSRIs) are known to be associated with treatment-induced mania.[7] In a study by Benvenuti et al., the occurrence of treatment-induced mania/hypomania was investigated during treatment with SSRIs and/or interpersonal psychotherapy (IPT). The study reported a prevalence of 3.0% in patients treated with an SSRI and 0.9% in patients treated with IPT alone.[4]

Fluoxetine, among the SSRIs, has been shown to have a higher likelihood of inducing mania compared to other SSRIs.[9] Numerous case studies and case series have reported the potential of citalopram to lead to mania.[3,6,10] The risk of inducing mania in bipolar patients with citalopram is comparable to the documented risk association with other SSRIs.[3] Previous case reports have identified that high doses of SSRIs may result in treatment-induced mania/hypomania.[2,10,11] However, it is worth noting that the literature suggests a low dose of 20 mg/day of citalopram as the threshold for inducing mania.[6,10] Some research indicates that the relatively low dosage of citalopram may reduce the risk of mood switching to mania.[12] Therefore, the focus of our case report is on a specific case where a low dose of citalopram led to treatment-induced mania.

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Case Presentation

Demographics

Diana Azad (DA) is a 24-year-old single female residing with her mother, father, and sister. She was referred to the Mental Health Treatment Center by the police under a judicial order for psychiatric assessment and treatment. Professionally, she works as the co-founder of a photographic and digital marketing agency. She was fluent in Kurdish and English. On August 23rd, 2022, at

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2:00 p.m., she was brought to a Mental Hospital by a police officer, accompanied by her mother. Earlier that morning, she was arrested following a complaint filed by four of her friends. The complaint alleged that she had publicly shared their private pictures on one of her social media platforms.

History of the Present Illness

DA denied having any problems and stated, “I don’t know why I’m here; the people who raised a legal complaint against me want to label me as crazy, but it’s them that should be here, not me.” Her mother, the main informant, reported that she has had a lack of sleep and irritability for the past 5 days.

On initial presentation, DA was irritable, aggressive, and restless. She showed disruptive behavior, including screaming in the wards and showing her will to leave the hospital. According to her mother, her current condition started around 2 months ago with symptoms of irritability, and impulsivity, and high sensitivity to even minor things. She was verbally aggressive towards her parents and couldn’t stand their presence. Her irritability and aggressive behavior were associated with disturbed sleep patterns, as she mentioned sleeping only 3–4 hours per night, thinking it to be more than enough.

Her current onset of symptoms was also associated with increased energy, talkativeness, and increased productivity at her work in the agency she recently co-founded. She also engaged in activities and social situations that could have had negative consequences. According to her mother, her friends have informed her on multiple occasions about her behavior, but she disregarded their concerns, leading to the filing of a legal complaint against her.

Her situation is also associated with increased self-esteem. In the past 2 months, she has been admitted to the hospital three times for similar complaints, she has changed multiple doctors; and before her latest admission, she was having sessions with an online therapist and a psychiatrist.

According to DA, her current situation is due to a friend’s betrayal; she got sick because all her close friends have abandoned her, and are now filing a complaint against her. Her mother further mentioned that she started taking a pill for her low mood two weeks before the onset of her symptoms 2 months ago. When asked about the pill and whether she had a prescription, DA replied, “my nickname is Lexa, short for Alexandra, the character known for protecting mankind in Greek mythology. One day a friend of mine sent me a pill with the brand name ‘Celexa’ and told me that it had my name on it. She then started using Citalopram 5 mg, half a tablet per day, without a prescription or professional supervision. She claimed that after a few days of using the medication, her energy and productivity peaked, and she became a new person who didn’t even need to sleep 7–8 hours per night.

Her appetite remained unchanged throughout her current state and she maintained unchanged eating patterns. Although the condition hasn’t affected her occupational life, her social life has been affected as all her friends abandoned her and left all sorts of contact with her. Her sexual desire has increased, showing inappropriate behavior by asking for a kiss from a female patient and massaging her shoulder in front of her mother. She has recently been suspicious of her surroundings; she thinks that her ex-girlfriend’s current boyfriend is spying on her and planning to harm her. She has also mentioned that a black car has followed her a few times and asked her to get in the car with them.

According to DA, certain companies and intelligence agencies are interested in hiring her, and she has been asked for these kinds of jobs on multiple occasions, but she has refused. She said that she enjoys life and is not thinking about death. Additionally, she didn’t have any suicidal thoughts and hasn’t attempted suicide.

Past Psychiatric History

In 2016, during her last year of secondary school when her parents were on the edge of getting divorced, she was feeling that stress was burning her out. Her condition initially started with low mood, feeling sad, and frequent crying. Her low mood was associated with gaining weight without following any specific diets. Her sleep was also affected, she found it difficult to initiate sleep at night. Her attention and concentration were not affected and she was doing well at school.

In 2016, following the emergence of the mentioned symptoms, she visited a psychiatrist for the first time, and she started taking medication which she had a good response to. After graduating and finishing her final secondary school, she stopped the medication.

Since then, she has been doing well. She attended college and got the third highest grade in her class leading to getting a bachelor’s degree in the College of Medical Laboratory Science.

In May 2022, following being threatened by her ex-girlfriend’s current boyfriend through tweets, she got stressed and felt she was in danger. That’s when she decided to take Citalopram on her own, and she was admitted twice before her current admission.

On her first admission, she stayed in the hospital for one day and left on her responsibility. Her second admission was at a private hospital during Eid; she stayed for three nights, and her condition improved. The psychiatrist prescribed aripiprazole and carbamazepine, which she hadn’t any complaints against.

DA’s mother says that she is suspicious about her daughter’s potential use of illegal substances because she doesn’t trust her friends. However, DA herself denied using any drugs, she says that she had been with friends in the same car when they were using them.

Medico-surgical History

The medical history is negative for any chronic medical illness or past operations and there were no known allergies to medication.

Family and Social History

DA currently resides with her mother, father, and sister. Her relationship with her parents was not good; she mentioned that they couldn’t understand her and it triggered her when they tried to invade her personal space and get involved with her private life. She is the eldest child of the family.

They denied having a history of mental illness in the family. They currently live in an apartment they own and have a moderate financial situation.

Mental State Examination

Upon examination, the patient is conscious, doesn’t appear to be drowsy, and is hyper-aroused. She was a slightly overweight woman who had a clean appearance. She has short hair and multiple tattoos on her arm, hand, and neck. She was wearing a white t-shirt and black jeans, which were appropriate for the place and situation.

Her behavior is friendly. She was calm, but sometimes gets triggered and leaves the room if she doesn’t like a question. She

also left the room a few times after asking permission to have a cigarette outside.

Her speech is pressured, spontaneous, and goal-directed in answering the questions. She provided too much detail on the questions she preferred and didn't answer the questions she didn't like.

Her mood was self-satisfied but sometimes agitated. Although her effect seemed happy and cheerful initially, she later got irritable and aggressive when her request to leave the hospital was denied.

DA exhibits abnormalities in her thought content. She shows grandiosity, but her grandiosity doesn't have a delusional form and can be attributed to her elevated mood and is congruent with her mood. DA also has the delusion of persecution; she told her mother to hide on two different occasions because some people are following them and may shoot them if they see them from outside the hospital.

She did not have hallucinations and had good cognitive functioning including memory, attention, and general knowledge.

Formulation and Interventions

She was diagnosed with bipolar disorder I, a manic episode. She didn't have insight into her condition at the beginning of her stay, although she didn't agree with the doctor's diagnosis and thinks she has attention deficit hyperactivity disorder (ADHD).

She was admitted to the hospital with her mother's companion. At the start, rapid tranquilizers were prescribed, including Haloperidol ampules and Diazepam, but as she refused injections, the following drugs in tablet form were prescribed.

Haloperidol tab 5 mg, 1 × 2

Olanzapine tab 10 mg, 1 × 2

Sodium valproate tab 500 mg, 1 × 3

Procyclidine tab 5 mg, 1 × 2

Lorazepam tab 2 mg, 1 × 1 at night

Discussion

According to DSM5 criteria, DA was diagnosed with bipolar disorder I, and developed a manic episode two weeks following the ingestion of citalopram for her low mood. She has essential criteria of a manic episode, including; a period of abnormally and persistently irritable mood and abnormally increased activity (Criterion A), associated with grandiosity, increased risk-taking behaviors, pressured speech, and decreased need for sleep (Criterion B), she was socially and occupationally impaired (Criterion C), lastly her condition did not relate to any substances or medical disease (Criterion A). Her persecutory delusion was related to a manic episode.

In practice, both in the US and in Europe, about (50–80%) of patients with bipolar disorder regularly take antidepressants for the long term.[5]

This case suggests that a low dose of citalopram has the potential to induce mania in patients affected by bipolar depression. To the best of our knowledge, this is the first report that refers to a patient who developed mania with low-dose citalopram monotherapy. Citalopram-induced mania has been reported in many studies, but all cases used a dose higher than the one used by DA.[3,9,12] Most of the cases used citalopram (20 mg/day).[10,12] Pravin D et al. reported four cases of citalopram-induced mania in children all cases except case 3 received citalopram doses greater than 20 mg. In case 3, a 14-year-old girl, mania was induced by the induction of 10 mg citalopram.[6]

The theory regarding this phenomenon was that antidepressants triggered mania or hypomania by influencing the central dopamine and serotonin systems.[7] Also, there is the possibility that SSRIs may have indirect effects on the central noradrenergic system.[10]

Major depressive episodes are present in patients with both bipolar disorder and major depressive disorder. Though it is often difficult for clinicians to differentiate between the two because the clinical symptoms and signs of bipolar depression and major depressive disorder display little difference, however, their consequences are clinically significant and necessitate rapid and proper therapeutic Interventions.[2,4] For this reason, recognizing those patients at risk for such an event is of vital clinical importance.[4] The two main recognizing features include patients in depressive episodes with a significant genetic load for bipolar illness and whose illness starts in adolescence or young adulthood may be especially at risk.[1,8] Although some clinical features seem to be related to a higher risk of antidepressant-induced mania among patients with unipolar depression, such as the severity of the current episode, less anxiety and physical complaints, less psycho-motor retardation, mood liability, and a high rate of relapse.[4]

Despite the fact that antidepressant-induced mania is an infrequent event, it occurs in 2.3% of patients treated for major depression.[4] The debate about antidepressant uses in bipolar depression centers on how frequently and for how long antidepressants should be used.[5] So, clinicians should be cautious about treating depressive patients with a high risk of bipolar disorder. To decrease this risk, these steps could be helpful: (A) Assessing for mania symptoms in all youth presenting with depressive symptoms, mostly youth with recurrent depressive symptoms, and assessing for a family history of bipolar disorder may decrease the probabilities of treatment-induced manic switching.[8] (B) Antidepressants should generally be used for severe cases of bipolar depression; psychological interventions should be used for mild cases.[5] (C) Starting treatments at lower doses and carefully increasing the dose is favorable.[2] (D) Antidepressants should be stopped after remission from the depressive episode.[5] (E) The prescription of SSRIs may need precise monitoring in patients with bipolar depression.[11,13] And lastly, concomitant use of mood stabilizers or antipsychotics in high-risk patients, especially lithium, may confer better protection against switching to mania/hypomania.[1,8]

Conclusion

Our case indicates that a low dose of citalopram may induce treatment-emergent mania. We support the idea that caution must be taken in treating depression with citalopram in young populations, even in the absence of a family history of affective illness. Although treatment at minor doses and with cautious upward titration may be advantageous in certain patients with bipolar depression and major depressive disorder to diminish the risk of mood switching.

Ethics Approval and Consent to Participate

The patient voluntarily participated, so a written informed consent with the permission to publish was obtained from the parents and the patient after remission. Also, the hospital authority, accepted it is publication after reviewing the case report.

Authors Contributions

Jaafar Omer Ahmed analyzed and interpreted the patient data and was a major contributor to writing the manuscript. Koyar Sherko M Salih collecting patients' data and reviewing manuscripts and Makwan Mohammed Abdulkareem contributes to writing and reviewing a manuscript. All authors read and approved the final manuscript.

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