



CASE REPORT

DOUBLE STIGMA IN PSYCHIATRY: MANAGING PSYCHOTIC BIPOLAR DEPRESSION IN AN LGBTQ+ PATIENT

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ABSTRACT

Introduction: Bipolar affective disorder with a severe depressive episode and psychotic features is a high-risk clinical state characterised by marked suicidality, prolonged morbidity and frequent readmission. When it occurs in a sexual- or gender-minority individual, the patient may carry two concurrently devalued identities — a minority sexual identity and a serious mental illness — creating a "double stigma" that can amplify interpersonal invalidation, impede help-seeking and destabilise the illness course. Clinical descriptions of this intersection remain scarce in Indonesia and the wider Southeast Asian region.

Case Illustration: A 22-year-old man in a same-sex relationship, with a two-year history of bipolar disorder, presented with panic-like anxiety, pervasive hopelessness, urges to self-cut, insomnia and mood-congruent command auditory hallucinations urging him to go to the beach to end his life, following an interpersonal

conflict and repeated accusations from his partner and peers that he was "pretending to be ill". The Beck Depression Inventory score was 33. He was diagnosed with bipolar affective disorder, current episode severe depression with psychotic symptoms (ICD-10 F31.5), and treated with lithium carbonate, a second-generation antipsychotic (olanzapine, subsequently quetiapine), alprazolam, supportive psychotherapy and family psychoeducation; persecutory ideation, vomiting, bloody diarrhoea and positional vertigo complicated the first admission. He was discharged on 2 September, self-escalated his medication doses, exhausted his supply prematurely, and relapsed with self-injury using broken glass after a further conflict with his partner. On 20 September he was readmitted with command hallucinations to drown himself or jump from a balcony, having picked up a glass shard at home, together with a seven-day intermittent fever, recurrent vomiting, epigastric pain and four episodes of haematochezia. Investigations showed mild leucocytosis ($11.33 \times 10^3/\mu\text{L}$), low-titre Widal agglutinins (1/80), a non-reactive provider-initiated HIV test, normal renal and hepatic indices, and a chest radiograph reported as cardiomegaly; digital rectal examination revealed a firm, fixed 0.5×0.5 cm mass at the 7 o'clock position. He was co-managed with internal medicine, continued on lithium carbonate 800 mg/day and olanzapine 15 mg/day with as-needed lorazepam, and scheduled for colonoscopy.

Discussion: The case illustrates how distal and proximal minority stressors, partner-level invalidation of psychiatric illness, early maternal loss and chronic familial invalidation can converge on a biologically vulnerable substrate to precipitate psychotic depressive relapse, non-suicidal self-injury used for affect regulation, and early readmission. It further highlights modifiable

clinical gaps: frequent antipsychotic switching, absent serum lithium, thyroid and electrocardiographic monitoring despite dose escalation and gastrointestinal fluid loss, benzodiazepine self-escalation and withdrawal, dispensing of large medication quantities to a high-risk patient, over-interpretation of a single Widal titre and a borderline glucose value, the use of tranexamic acid for minor lower gastrointestinal bleeding, and the risk of diagnostic overshadowing. Ethically conducted HIV testing, attention to the acute seroconversion window, confidentiality regarding sexual orientation, structured safety planning and partner-inclusive, affirmative psychoeducation emerge as key components of care.

Conclusion: Managing psychotic bipolar depression in an LGBTQ+ patient requires an integrated biopsychosocial approach that treats the mood episode with guideline-concordant, adequately monitored pharmacotherapy, systematically excludes and manages somatic comorbidity, and explicitly addresses intersectional stigma through affirmative, confidential and partner-inclusive psychoeducation and suicide-prevention measures.

Keywords: bipolar disorder; psychotic depression; sexual and gender minorities; social stigma; suicide

INTRODUCTION

Background

Bipolar affective disorder is a recurrent, lifelong mood disorder in which depressive episodes account for the greater part of symptomatic time and functional impairment. Current international guidance from the Canadian Network for Mood and Anxiety Treatments (CANMAT) and the International Society for Bipolar Disorders (ISBD) emphasises that the depressive pole is both the most disabling and the most difficult to treat, that suicide risk assessment must be integral to every clinical encounter, and that pharmacotherapy should be combined with structured psychosocial interventions. When a depressive episode is accompanied by psychotic features, the clinical picture becomes more severe: psychotic depression is associated with longer hospitalisations, lower sustained remission, higher relapse and readmission liability, poorer functional outcomes and increased suicidality compared with non-psychotic depression. Registry-based meta-analytic evidence further indicates that people with bipolar disorder are approximately 8.7 times more likely to die by suicide than the general population, underlining the lethality of this condition.¹⁻³

Sexual- and gender-minority (SGM) individuals experience a disproportionate burden of mental disorders. The minority stress model explains this excess as the consequence of a hostile social environment in which prejudice events (distal stressors), expectations of rejection, identity concealment and internalised stigma (proximal stressors) accumulate over time. Population-based meta-analyses have shown that lesbian, gay and bisexual people have approximately two- to five-fold higher odds of depressive disorders and suicidality than heterosexual people, and large cohort data link cisgender sexual-minority men with an almost two-fold higher odds of bipolar disorder. Two decades after its original articulation, minority stress theory remains the dominant explanatory framework for these disparities, while recognising that stress exposure is modified by social support and community connectedness.⁴⁻⁷

When a person simultaneously holds a stigmatised sexual identity and a serious mental illness, the two stigmas do not merely co-exist; they intersect. "Intersectional stigma" describes the convergence of multiple devalued identities within a single person and their joint effects on health, which are frequently more than additive. Structural stigma — including laws, institutional policies and cultural norms — has been shown consistently to increase the risk of poor mental health among LGBTQ+ individuals. Experimental work suggests that anti-stigma interventions may reduce mental-illness stigma without reducing SGM-related prejudice, and a systematic review of LGBTQ+ experiences of inpatient psychiatric care documented non-inclusive intake procedures, discrimination, silencing and fear across admission, ward stay and discharge. These data suggest that "double stigma" operates both within the community and within the health system itself.^{8–11}

The Indonesian and broader Southeast Asian context magnifies these pressures. In a survey of 416 men who have sex with men and transgender women in Bali — the province in which the present patient lives — high levels of stigma were reported by 50.5% of men who have sex with men, discrimination by 35.5%, and family rejection or lack of family awareness was associated with greater stigma. Regional analyses of the Association of Southeast Asian Nations (ASEAN) highlight limited legal recognition, inadequate anti-discrimination protection and, in some jurisdictions, criminalisation, all of which are hypothesised to intensify minority stress. Among young sexual-minority adults, internalised homophobia, perceived stigma and experienced victimisation are independently associated with psychological distress, suicidal thoughts and lifetime suicide attempts.^{12–14}

The family and relational environment is a well-established determinant of the course of bipolar disorder. Family-focused psychoeducational treatment reduces relapse and improves depressive symptoms, and its benefit is greatest in families with high expressed emotion, that is, families characterised by criticism, hostility or emotional over-involvement. Developmental adversity is also relevant: childhood adversity is approximately 2.6 times more common in bipolar disorder than in non-clinical controls, with emotional abuse showing a particularly robust association, and childhood trauma is linked to earlier onset, greater affective instability, substance misuse and suicide attempts. In a young adult whose primary attachment figure has died and whose

remaining family relationships are experienced as cold or hostile, an intimate partner may become the principal source of emotional regulation, so that invalidation by that partner may be experienced as a powerful re-traumatising stressor.¹⁵⁻¹⁷

Non-suicidal self-injury (NSSI) and command auditory hallucinations are two clinical phenomena that sharply raise risk in this population. In a national multicentre survey of more than 1,000 patients with bipolar disorder, over 40% of those in depressive or mixed episodes reported NSSI, over 50% reported suicidal ideation, and suicidal ideation was the most central node linking self-harm and depressive symptoms. Prior NSSI is associated with a five-fold increase in the odds of a subsequent suicide attempt, independent of co-morbid mental disorders. Command auditory hallucinations, in contrast to auditory hallucinations in general, are specifically associated with active suicidal ideation and recent suicide attempts among psychiatric inpatients.¹⁸⁻²⁰

Finally, people with serious mental illness frequently present with physical symptoms that may be misattributed to their psychiatric condition, a phenomenon termed diagnostic overshadowing, which contributes to delayed diagnosis and excess mortality. Emergency department staff identify complex presentations, communication difficulties, time pressure and stigmatising attitudes as drivers of this error. Conversely, mental health settings are important opportunities for detecting infectious comorbidities: HIV prevalence among people receiving mental health services has been reported to be about four times that of the general population, with homosexual or bisexual identity among the associated characteristics, yet fewer than half of people with serious mental illness have been tested within the previous year, and testing in psychiatric settings raises specific ethical challenges.²¹⁻²⁴

Research Gap

Despite abundant epidemiological evidence of mental health disparities among SGM populations, SGM status is rarely assessed or reported in studies of serious mental illness, leaving substantial uncertainty about whether SGM individuals experience higher rates or greater severity of schizophrenia-spectrum and bipolar disorders and how minority stress should be addressed in their treatment. Mental health interventions for sexual-minority people seldom integrate intersectionality: in a systematic review of 43 interventions, only 16.3% adequately considered the

complex effects of intersecting disadvantaged positions. Clinical case-level descriptions that integrate (i) the phenomenology and pharmacotherapy of psychotic bipolar depression, (ii) the interpersonal dynamics of partner invalidation within a same-sex relationship, (iii) the parallel work-up of somatic comorbidity and (iv) the ethics of HIV testing and confidentiality are virtually absent from the Indonesian literature.^{11,25,26}

Novelty

To the best of the authors' knowledge, this is among the first Indonesian case reports to describe psychotic bipolar depression in an LGBTQ+ patient through an explicit double-stigma (intersectional) lens, integrating a psychodynamic formulation with a critical, evidence-based appraisal of pharmacological, somatic and ethical management across two consecutive admissions and an intervening outpatient relapse in a regional general hospital in Bali. The report also introduces the concept of "partner denial" — a partner's disbelief in the legitimacy of the psychiatric diagnosis — as a clinically relevant precipitant that sits at the intersection of mental-illness stigma and the relational context of an SGM patient, and proposes a partner-inclusive, affirmative psychoeducation framework adapted to a setting in which family acceptance cannot be assumed.^{12,25}

Objectives

General objective: to describe and critically analyse the comprehensive management of bipolar affective disorder, current episode severe depression with psychotic symptoms, in a young adult LGBTQ+ patient experiencing double stigma, in order to derive practical lessons for psychiatric practice in Indonesia.^{1,25}

Specific objectives: (1) to document the longitudinal clinical course, mental status, psychometric profile, investigations and treatment across two admissions and the intervening outpatient period; (2) to formulate the case psychodynamically and within the minority stress and intersectional stigma frameworks; (3) to appraise the pharmacological management — mood stabiliser, antipsychotic and benzodiazepine use and their monitoring — against current evidence; (4) to evaluate the medical work-up of fever, vomiting and haematochezia with respect to diagnostic overshadowing and diagnostic accuracy; (5) to discuss the ethical conduct of provider-

initiated HIV testing and confidentiality of sexual orientation; and (6) to propose a partner-inclusive, affirmative psychoeducation and suicide-prevention plan.^{1,21,24}

Benefits

For clinical practice, the report offers a structured checklist for managing psychotic bipolar depression in SGM patients, including safety planning, lithium and benzodiazepine stewardship, and systematic exclusion of somatic causes. **For health institutions**, it highlights system-level opportunities — routine, consent-based collection of SGM information, confidentiality safeguards, integrated consultation-liaison pathways and post-discharge follow-up within seven days. **For education**, it provides residents and specialists with an integrated biopsychosocial and psychodynamic teaching case. **For research**, it generates testable hypotheses about the role of partner invalidation and intersectional stigma as proximal precipitants of relapse and readmission in bipolar disorder. **For patients and their partners**, it advocates affirmative, non-judgemental care that may reduce internalised stigma and improve engagement.^{9,13}

CASE ILLUSTRATION

Patient Identity and Household Composition

Mr. D is a 22-year-old Balinese man, the second of two siblings, who works as an administrative staff member at a private clinic (his father believed he worked at a medical centre and was unsure of his exact role). He lives with his father, a paternal uncle with a history of stroke, and his grandmother; his mother died several years before presentation. He is in a romantic relationship with a man and identifies within the LGBTQ+ spectrum; his specific self-identified sexual-orientation label was not recorded. He denied alcohol, caffeine abuse or illicit substance use.

Chief Complaint

Very severe, panic-like anxiety with a sensation of choking, pervasive sadness, emptiness and hopelessness, strong urges to cut himself, and auditory hallucinations commanding him to end his life.

History of Present Illness

Antecedent events

Approximately three days before the index presentation, the patient had been admitted to a private (military) hospital for persistent restlessness and panic. Shortly after discharge he declined an invitation from friends to go out because he wished to rest; this led to a quarrel in which he was accused of "only pretending to be ill to attract attention". According to the treating team's summary, his male partner shared this disbelief and openly questioned the legitimacy of his psychiatric diagnosis ("partner denial"). During the night of 28 August he ruminated on the conflict and could not sleep; he self-administered two tablets of alprazolam without relief.

First admission (29 August – 2 September 2026)

On 29 August he presented to the emergency department with a panic-like attack comprising choking sensations, subjective dyspnoea, cold sweating, palpitations, chest pain and an intense fear of dying, superimposed on several days of severe sadness, hopelessness, emptiness and the conviction that his life would never improve; he cried during the interview. Urges to self-cut had returned. He explained that cutting had previously provided transient relief and served as an outlet for emotions he could not express otherwise; when the urge emerged, his whole body felt rigid, followed by weakness and nausea. For several days he had heard a male voice inviting him to go to the beach to end his life; initially he could ignore it, but the voice was becoming more insistent. He denied visual hallucinations. Sleep had been poor for two nights and appetite was reduced. He was receiving supplemental oxygen by mask on account of subjective breathlessness, although peripheral oxygen saturation was 98%.

Admission was arranged once a family member (his father) could accompany him. Over the following days, depressive mood and command hallucinations persisted (the voices told him "to just die" and appeared when he was idle), and on 31 August he reported feeling watched from the corners of the room, consistent with emerging persecutory ideation. Gastrointestinal symptoms developed: two episodes of vomiting on the evening of 30 August, three episodes of loose stool with mucus and blood on the morning of 31 August, and mild epigastric tenderness. On 1 September he developed positional vertigo with nausea. By 2 September his mood had improved, suicidal intent was denied, the hallucinations had ceased and he slept from 23:00 to 07:00; he was discharged with a clinic appointment on 8 September.

Outpatient relapse (7 – 8 September 2026)

On 7 September, one day before the scheduled review, he returned because his medication had run out: he had increased the doses himself (lithium carbonate 400 mg three times daily, alprazolam 0.5 mg three times daily and quetiapine 100 mg twice daily). After discharge he had quarrelled with his partner and friends, none of whom believed he was ill. He reported excessive sadness, anergia, anhedonia, poor concentration, insomnia for one week (no sleep at all the previous night), reduced appetite and five episodes of vomiting the previous day. Voices — sometimes male, sometimes female — invited him to the beach "to heal himself" or ordered him to slash his hands. On 8 September he disclosed that the self-harm commands at night had become uncontrollable, and that he had broken a glass and cut his left hand; he had also attended the emergency department the previous day for repeated vomiting and self-harm urges. He reported severe evening headache ("as if my head would burst"), fatigue, persistent hunger and post-prandial vomiting.

Readmission (20 September 2026 – ongoing at the time of writing)

On 20 September he returned to the emergency department with anxiety, fear, restlessness and palpitations since the morning, and command hallucinations urging him to kill himself, to "throw himself into the sea" and to jump from a balcony. At home he had picked up a shard of glass intending, according to the emergency note, to kill himself, but did not act; in the psychiatric interview the following morning he clarified that he had intended to injure — not kill — himself, "to transfer the pain in my heart to my body". He had not taken alprazolam for three days because the supply was exhausted, had vomited all his psychiatric medication that morning, and reported epigastric pain, nausea, vomiting, subjective dyspnoea, fresh rectal bleeding on four occasions since the morning, and intermittent fever for seven days. A week earlier he had attended an emergency department for seven days of fever and epistaxis, and he had had oral ulcers for about two weeks that had healed five days before admission. He also reported cloudy urine with dysuria. He was admitted under internal medicine with psychiatric co-management.

Past Psychiatric and Medication History

Bipolar disorder was first diagnosed in 2024; he had been treated by psychiatrists in Java and Bali for approximately two years. Previous medications included olanzapine, lithium carbonate

(Frimania®), alprazolam and risperidone. Prior manic or hypomanic episodes were not described in detail in the available records. He reported that his mood changed particularly under stress and that he habitually self-injured (cutting) when restless, angry or overwhelmed. There was one psychiatric-related admission at a private hospital immediately before the index presentation. No family history of mental illness was reported.

Past Medical History

Hypertension, diabetes mellitus, heart disease and drug or food allergies were denied. No previous surgery was documented.

Family History and Family Dynamics

Maternal loss. His mother died several years ago; the loss was experienced as unresolved and is associated with a chronic sense of emptiness and fear of abandonment. **Paternal relationship.** Although the father lives with him and accompanied him during both admissions, the patient experiences the relationship as emotionally distant and perceives his father as disengaged from his psychological difficulties; the father described him as introverted and socially withdrawn.

Sibling relationship. The patient describes his older sibling as verbally and psychologically hostile, as slandering him before the extended family, and reports that he financially supports extended-family events yet continues to feel rejected. These family-dynamic data derive from the patient's own account as summarised by the treating team and were not independently corroborated.

Psychodynamic Formulation

(1) **Core emptiness:** the death of his mother removed the principal protective attachment figure, leaving a deep-seated sense of emptiness and a heightened fear of abandonment. (2) **Family invalidation and hostility:** a disengaged father and a hostile, exploitative sibling produced chronic emotional invalidation; attempts to earn recognition through financial contribution were met with rejection, fostering internalised anger. (3) **Displacement of attachment needs onto the partner and "partner denial":** lacking familial affection, he invested his attachment needs in his partner; the partner's disbelief in his illness re-enacted earlier experiences of rejection and was experienced as re-traumatising. (4) **Turning against the self and psychotic regression:** unable to direct aggression outward, he turned it against himself through cutting; when stress exceeded the adaptive

capacity of the ego, regression to a psychotic level occurred, with command voices that may be understood as the externalisation of a harsh, punitive superego. This formulation is offered as a clinically useful, hypothesis-generating narrative rather than as a causal explanation.

Physical Examination

Across both admissions he was alert (Glasgow Coma Scale E4V5M6). Blood pressure ranged from 96/61 to 154/88 mmHg (140/98 mmHg on the first evening; 154/88 mmHg at readmission), pulse 62–90 beats/min, respiratory rate 20/min, axillary temperature 36.0–37.0 °C (with a reported seven-day history of intermittent fever before readmission) and SpO₂ 97–100%. Conjunctivae were not pale and sclerae were not icteric. Heart sounds were single and regular without murmur; lungs were clear. The abdomen showed normal bowel sounds with epigastric tenderness and no distension. Extremities were warm with capillary refill < 2 s; superficial abrasions and cutting scars were noted on the left hand/forearm. **Digital rectal examination (21 September):** minimal perianal hyperaemia, no external lump and no blood on inspection; good sphincter tone, smooth mucosa, and a firm, fixed, minimally tender mass of approximately 0.5 × 0.5 cm palpable at the 7 o'clock position. Height 170 cm; weight 65–70 kg; body-mass index 22.5–24.2 kg/m² (the nutrition notes recorded 26.71 kg/m² on 1 September, which does not correspond to the documented height and weight). Morse Fall Scale 10 (low risk) at the first admission and 25 (moderate risk) at readmission.

Mental Status Examination

Serial mental status findings are summarised in **Table 1**. In brief, the patient was consistently fully conscious and oriented, with logical-realistic and coherent thought; mood was depressive and anxious with an appropriate affect; thought content included suicidal ideation, preoccupation with interpersonal conflict and, later, persecutory ideation and preoccupation with physical symptoms; perception was marked by persistent command auditory hallucinations without illusions or visual hallucinations; and there was mixed-type insomnia without raptus or hypobulia. Psychomotor activity remained calm.

Table 1. Serial mental status examination

Domain	29 Aug (ED)	31 Aug	1–2 Sep	7–8 Sep (OPD)	21–22 Sep
General appearance / rapport	Appropriate; sad face; reduced verbal & visual contact	Sad; good contact	Uncomfortable → calm; smiles; good contact	Appropriate; calm; good contact	Appropriate; calm; adequate contact
Consciousness / orientation	Clear; oriented	Clear; oriented	Clear; oriented	Clear; oriented	Clear; oriented
Mood / affect	Depressive / depressive	Depressive / depressive	Depressive (improving) / broad	Depressive–anxious / broad	Anxious / restricted
Thought form / stream	Logical-realistic / coherent	Logical-realistic / coherent	Logical-realistic / coherent	Logical-realistic / coherent	Logical-realistic / coherent
Thought content	Suicidal ideation; preoccupation with conflict	Suicidal ideation; preoccupation; persecutory ideation	History of suicidal ideation; persecutory ideation (fading)	History of suicidal ideation; persecutory ideation	Preoccupation with physical condition and conflict
Perception	Command AH (go to beach to die)	Command AH ("just die")	Male voice in bathroom urging death → absent on 2 Sep	Male/female voices: beach; slash hands	Female voice urging self-harm; recognised as unreal
Instinctual	Mixed	Mixed	Mixed	Severe	Mixed

drives	insomnia; no raptus/hypobulia	insomnia	insomnia → slept 23:00– 07:00	insomnia	insomnia; waking at 02:00
Psychomotor	Calm	Calm	Calm	Calm	Calm

AH, auditory hallucinations; ED, emergency department; OPD, outpatient department.

Psychometric and Risk Assessment

On admission the Beck Depression Inventory (BDI) score was 33 (severe depressive symptoms), the Beck Anxiety Inventory (BAI) score 10 and the institutional Assault and Violence score 8; the same scores were carried forward in subsequent notes rather than re-administered. A nursing suicide-risk instrument on 8 September scored 2 (low risk), which contrasts with the concurrent disclosure of uncontrollable self-harm commands and recent self-injury. The Global Assessment of Functioning (GAF) was estimated at 31–40 on admission and 51–60 at discharge from the first admission. Projective tests (Wartegg, House–Tree–Person and a free-writing task) were requested on 31 August; results were not available in the record at the time of writing.

Laboratory and Imaging Investigations

Table 2. Laboratory and radiological results

Date	Investigation	Result	Interpretation
30 Aug	Complete blood count	Leucocytes $7.58 \times 10^3/\mu\text{L}$; Hb 15.0 g/dL; Hct 44.2%; platelets $228 \times 10^3/\mu\text{L}$	Within normal limits
30 Aug	Renal function	Urea 26 mg/dL; creatinine 0.8 mg/dL	Normal
31 Aug	Electrolytes	Na 143; K 4.2; Cl 107 mmol/L	Normal
31 Aug / 1 Sep	Stool examination	Requested; no specimen obtained	Not performed
20 Sep	Complete blood count	Leucocytes $11.33 \times 10^3/\mu\text{L}$ (H); RBC $4.95 \times 10^6/\mu\text{L}$; Hb 15.1 g/dL; Hct 44.6%; MCV 90.1 fL; MCH 30.5 pg;	Mild leucocytosis; no anaemia

		MCHC 33.9 g/dL*; platelets 282 ×10 ³ /μL; lymphocytes 31.0%	
20 Sep	Chemistry	Urea 29 mg/dL; creatinine 1.0 mg/dL; AST 23 U/L; ALT 22 U/L; random glucose 78 mg/dL (flagged L); ward capillary glucose 125 mg/dL (23:50, after dextrose)	Normal renal/hepatic indices; glucose within physiological range
20 Sep	Electrolytes	Na 141; K 3.8; Cl 108 mmol/L	Normal
20 Sep	Chest radiograph (AP)	Cardiomegaly; lungs unremarkable	Requires confirmation (see Discussion)
21 Sep	Bleeding / clotting time	BT 1'30"; CT 10'30"	Within reference ranges
21 Sep	Widal (tube)	S. Typhi O & H negative; S. Paratyphi AO, BO, AH, CH negative; S. Paratyphi CO 1/80; S. Paratyphi BH 1/80	Low, single titres; non-diagnostic
22 Sep	Urinalysis	Yellow, clear; SG 1.020; pH 6.0; leucocyte esterase, nitrite, protein, ketone, bilirubin, blood negative; glucose normal; sediment RBC 1–2/HPF, WBC 0–1/HPF, squamous epithelium 3–5/LPF; casts, crystals, bacteria negative	Normal; no urinary tract infection
22 Sep	HIV test (PITC)	Non-reactive	See Discussion (window period)
Not	Serum lithium,	—	Recommended (see

done	TSH/FT4, calcium, ECG, blood culture, lipid profile, HbA1c		Discussion)
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**Reported in the record as "g/L"; the value is consistent with g/dL. AP, anteroposterior; BT, bleeding time; CT, clotting time; H, high; L, low; PITC, provider-initiated testing and counselling.*

Diagnosis (Multiaxial Formulation)

Table 3. Multiaxial diagnosis

Axis	Diagnosis
I	Bipolar affective disorder, current episode severe depression with psychotic symptoms (ICD-10 F31.5)
II	Anxious, introverted personality traits with interpersonal hypersensitivity; borderline personality features to be evaluated longitudinally in euthymia (no Axis II diagnosis established)
III	(1) Febrile illness, day 7–8, presumed bacterial infection — aetiology unconfirmed (low-titre Widal); (2) haematochezia with a 0.5 × 0.5 cm fixed rectal mass at 7 o'clock — under evaluation (colonoscopy scheduled); acute diarrhoea during the first admission; (3) dyspepsia; (4) random glucose 78 mg/dL recorded as "hypoglycaemia" (within physiological range on re-evaluation); (5) cardiomegaly on AP chest radiograph — to be confirmed
IV	Double stigma (sexual-minority identity and serious mental illness); partner denial of psychiatric illness; conflicts with peers; unresolved maternal loss; perceived paternal emotional distance; sibling hostility and financial exploitation
V	GAF 31–40 on admission; 51–60 at discharge from the first admission

Management

Management comprised psychiatric pharmacotherapy, internal medicine treatment, non-pharmacological interventions and nursing care. The chronological evolution of psychotropic prescribing is presented in **Table 4** and the principal medical treatments in **Table 5**. Non-pharmacological measures included supportive psychotherapy at every visit, psychoeducation of the father, psychological testing, nursing interventions for suicide risk (identification of warning signs, a hazard-free environment and close observation), hallucination management (teaching distraction and reality-testing strategies, encouraging disclosure to a trusted person), nausea management and fall-prevention measures (yellow fall-risk clip, bed rails, orientation to the room). Dietetic assessment prescribed a regular rice-based diet of 2,146 kcal/day (protein 76 g, fat 59 g, carbohydrate 331 g) in three main meals and two snacks.

Table 4. Chronology of psychotropic pharmacotherapy

Date	Antipsychotic	Mood stabiliser (lithium carbonate)	Anxiolytic / hypnotic	Rationale / event
29 Aug	Olanzapine 5 mg stat, then 10 mg nocte	200 mg mane	Alprazolam 0.5 mg PRN	Admission; F31.5
30 Aug	Olanzapine 5 mg mane + 10 mg nocte	200 mg bd (400 mg/day)	Alprazolam 0.5 mg PRN	Persistent symptoms; labs ordered
31 Aug	Olanzapine stopped → quetiapine XR 200 mg nocte	200 mg mane + 400 mg nocte (600 mg/day)	Alprazolam 0.5 mg bd scheduled	Persecutory ideation; nausea; IM consult
1 Sep	Quetiapine XR 100 mg mane +	600 mg/day	Alprazolam 0.5 mg bd	Mood improving; vertigo

	200 mg nocte (nursing record: 100 mg + 100 mg)			
2 Sep (discharge)	Quetiapine 50 mg mane + 100 mg nocte	600 mg/day	Alprazolam 0.5 mg bd	Remission of AH; 15-tablet alprazolam supply
2–7 Sep (self- administered)	Quetiapine 100 mg bd	400 mg tds (1,200 mg/day)	Alprazolam 0.5 mg tds	Self-escalation; supply exhausted early
7 Sep	Quetiapine → olanzapine 10 mg bd	400 mg bd (800 mg/day)	Alprazolam 0.5 mg bd	Relapse; partner conflict
8 Sep	Olanzapine 10 mg bd (60 tablets)	400 mg bd (60 tablets)	Alprazolam 0.5 mg bd PRN (10 tablets); omeprazole 20 mg bd	Self-injury with glass; follow-up set at 1 month
20 Sep	Olanzapine 10 mg PO	Continued	— (alprazolam exhausted 3 days earlier)	Readmission
21 Sep	Olanzapine 10 mg nocte	400 mg bd	Lorazepam 1 mg bd PRN panic	Command AH; anergia; anhedonia
22 Sep	Olanzapine 5 mg	400 mg bd	Lorazepam 1	Persistent AH;

	mane + 10 mg nocte		mg bd PRN	improving mood
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bd, twice daily; mane, morning; nocte, at night; PRN, as needed; tds, three times daily; XR, extended release.

Table 5. Internal medicine management

Period	Working diagnosis	Treatment
30 Aug (night)	Vomiting	Ranitidine 25 mg IV once
31 Aug – 2 Sep	Acute diarrhoea (with mucus/blood); dyspepsia	Ringer's lactate 20 drops/min; attapulgate 2 tablets per loose stool (max 8/day); omeprazole 40 mg IV bd; ondansetron 4 mg IV tds PRN; stool analysis requested; discharged on omeprazole 20 mg bd
20 Sep – ongoing	Fever day 7–8 due to presumed bacterial infection; haematochezia under observation; dyspepsia; "hypoglycaemia (78 mg/dL)"	Normal saline 20 drops/min; dextrose 40% bolus then dextrose 5% 20 drops/min; ceftriaxone 1 g IV bd (day 3 on 22 Sep); omeprazole 40 mg IV bd; ondansetron 4 mg IV tds; tranexamic acid 500 mg IV tds; paracetamol 500 mg tds; sucralfate syrup 3 × 1 cth; capillary glucose monitoring; Widal, urinalysis, PITC; colonoscopy scheduled 24 Sep (bowel preparation from 23 Sep)

Clinical Course and Follow-up

Table 6. Timeline of the clinical course

Date	Key events
~26 Aug 2026	Private hospital admission for restlessness and panic
28 Aug	Conflict with friends/partner; accused of feigning illness; insomnia; self-

	administered alprazolam 1 mg
29 Aug	ED: panic-like attack, severe depression, NSSI urges, command AH; BDI 33, BAI 10; F31.5; admitted
30 Aug	Lithium and olanzapine increased; normal CBC and renal function; two episodes of vomiting
31 Aug	Persecutory ideation; switch to quetiapine; lithium 600 mg/day; alprazolam scheduled; bloody mucoid diarrhoea ×3; IM co-management
1 Sep	Positional vertigo; suicidal wish absent; AH persists; father's heteroanamnesis
2 Sep	AH absent; slept well; discharged (quetiapine 150 mg/day, lithium 600 mg/day, alprazolam 1 mg/day)
2–7 Sep	Self-escalation of all medications; conflict with partner and friends; recurrent vomiting
7 Sep	OPD: relapse; quetiapine → olanzapine 20 mg/day; lithium 800 mg/day
7–8 Sep	ED visit for vomiting and self-harm urges; self-injury with broken glass (left hand); OPD review with 30-day supply; next review 6 Oct
16 Sep	CBC ordered (no result recorded)
20 Sep	ED: command AH (sea, balcony), picked up glass shard, fever ×7 days, haematochezia ×4, vomiting; leucocytosis; readmitted under IM with psychiatric co-management
21 Sep	DRE: 0.5 cm fixed rectal mass; Widal low titres; lorazepam PRN introduced
22 Sep	Haematochezia and vomiting ceased; anxiety reduced; AH persists (female voice); urinalysis normal; PITC non-reactive; olanzapine 15 mg/day; colonoscopy planned 24 Sep

At the time of writing (22 September 2026), the patient remained an inpatient. Anxiety and fearfulness had decreased, palpitations and dyspnoea had resolved, rectal bleeding had stopped and

he was able to eat three meals and bathe twice daily. He continued to hear a female voice instructing him to harm himself, which he recognised as unreal but found highly distressing; sleep was interrupted at 02:00. The results of colonoscopy and projective psychological tests are pending.

Prognosis

Ad vitam: dubia ad bonam, conditional on effective suicide prevention and exclusion of serious somatic pathology. **Ad functionam:** dubia; the patient is young, employed, cooperative and insightful, but has recurrent psychotic depressive episodes, persistent self-harm, benzodiazepine self-escalation and limited social support. **Ad sanationem:** dubia ad malam, given two readmissions within one month, persistent command hallucinations and ongoing relational stressors. Favourable factors include retained insight, adherence when supervised, the father's presence and absence of substance use.

DISCUSSION

Diagnostic Considerations

The index episode fulfils the ICD-10 criteria for bipolar affective disorder, current episode severe depression with psychotic symptoms (F31.5): the patient had an established diagnosis of bipolar disorder since 2024, and the current episode combined pervasive depressed mood, hopelessness, anhedonia, anergia, insomnia, reduced appetite and a BDI score of 33 with mood-congruent command hallucinations and persecutory ideation. Psychotic features define a higher-risk depressive subtype associated with greater severity, longer hospitalisation, higher relapse liability and increased suicidality, which is consistent with the two admissions within one month observed here. CANMAT/ISBD guidance nevertheless requires that the bipolar diagnosis be anchored in a documented history of mania or hypomania; because such episodes were not described in the available records, collateral history and prior records should be obtained, since the distinction between bipolar and unipolar psychotic depression has direct implications for the use of antidepressants and the choice of maintenance therapy.^{1,2}

Several differential and co-morbid diagnoses merit consideration. Chronic emptiness, fear of abandonment, NSSI used for affect regulation and intense reactivity to interpersonal rejection raise the possibility of co-morbid borderline personality features; auditory verbal hallucinations occur in

22–50% of patients with borderline personality disorder and are associated with more suicide plans, suicide attempts and hospitalisations, while NSSI in psychiatric outpatients is most prevalent among those with personality disorders and is associated with a seven-fold higher prevalence of suicide attempts. Personality should therefore be assessed longitudinally during euthymia rather than during the acute episode. Organic contributors were partly excluded (non-reactive HIV test, no substance use, normal renal and hepatic function), but thyroid function, serum lithium and calcium were not measured, and abrupt interruption of alprazolam three days before readmission may have contributed to rebound anxiety, insomnia and perceptual disturbance. The emergency working diagnosis of "acute psychosis, differential diagnosis organic mental disorder" was therefore appropriate pending these investigations.^{27,28}

Double Stigma: Minority Stress Meets Mental-Illness Stigma

Minority stress theory proposes that sexual-minority people are exposed to excess, socially generated stress — prejudice events, expectations of rejection, concealment and internalised stigma — that is additive to general life stress and explains their excess prevalence of mental disorders; social support and community connectedness act as buffers. Population-based meta-analysis confirms higher odds of depression and suicidality among lesbian, gay and bisexual people, and in a cohort of nearly 270,000 participants cisgender sexual-minority men had 1.87 times higher odds of bipolar disorder than cisgender heterosexual men. These associations do not imply that sexual orientation is pathogenic; rather, they reflect the cumulative burden of stigma and minority stress.^{4–7}

Mechanistically, victimisation, harassment, lower family and social support, low self-esteem and rumination mediate the depression disparity between sexual-minority and heterosexual individuals. Disclosure of sexual orientation ("outness") is double-edged: it is associated with greater social support and fewer depressive symptoms, but also with greater exposure to discrimination. In cross-national World Mental Health Survey data, lower openness with family partially explained the excess risk among sexual-minority women, although not among men, illustrating that the protective role of family acceptance is heterogeneous. In the present patient, low perceived family support, uncertain family awareness of his sexual orientation and dependence on a single intimate relationship left few buffers against minority stress.^{29–31}

The concept of intersectional stigma captures what the treating team termed "double stigma": the convergence of stigmatised identities whose joint effect on health is complex and not simply additive. Structural stigma — societal norms and institutional policies — is consistently associated with poorer LGBTQ+ health. Importantly, the two stigmas may require distinct interventions: in a randomised trial, digital stories told by SGM individuals living with mental illness reduced mental-illness stigma but did not reduce SGM-related prejudice. Within psychiatric wards themselves, LGBTQ+ patients report non-inclusive intake tools, lack of cultural humility, discrimination, silencing and fear, and a lack of community resources at discharge — each of which can undermine the therapeutic alliance at the very time a patient is most vulnerable.^{8–11}

A particularly salient feature of this case is that the most damaging stigma was enacted not by strangers but by the patient's own partner and peers, who dismissed his illness as attention-seeking. This form of invalidation sits at the intersection of mental-illness stigma and the relational ecology of an SGM individual, in whom the partner may be the principal — and sometimes the only — secure attachment. In Bali, more than half of men who have sex with men report high stigma, and family rejection or non-awareness of their status is associated with higher stigma; ASEAN-level analyses identify limited legal protections as drivers of minority stress; and among young sexual-minority adults, perceived stigma and internalised homophobia are associated with psychological distress and suicidal ideation. Taken together, these data suggest that the patient's relapse and readmission were precipitated by a stressor that was simultaneously a mental-illness stigma event and a loss of the key buffer against minority stress.^{12–14}

Developmental Vulnerability and Psychodynamic Understanding

The patient's history of maternal loss, perceived paternal disengagement and sibling hostility is consistent with a substantial burden of early and ongoing adversity. Childhood adversity is 2.63 times more frequent in bipolar disorder than in non-clinical controls, with emotional abuse showing the strongest association (odds ratio 4.04). Childhood trauma is associated with earlier onset, more severe clinical expression and a higher risk of suicide attempts, and affective lability statistically mediates the association between childhood trauma and suicide attempts, mixed episodes and anxiety co-morbidity. A recent meta-analysis found that adverse childhood experiences nearly

double the risk of suicidal behaviour in affective disorders (odds ratio 1.98). The age at maternal death and the nature of early caregiving were not documented and should be clarified, ideally with a structured instrument such as the Childhood Trauma Questionnaire.^{16,17,32,33}

The psychodynamic formulation — core emptiness following maternal loss, chronic invalidation, displacement of attachment needs onto the partner, aggression turned against the self and regression to a psychotic level with punitive voices — offers a coherent narrative linking developmental history with the current presentation. Clinically, the partner's hostile disbelief can be understood as a form of high expressed emotion (criticism and hostility). This matters therapeutically: in the landmark randomised trial of family-focused treatment, the greatest benefits in relapse prevention and depressive symptoms were seen in patients whose families were high in expressed emotion, suggesting that targeting the invalidating relationship directly may be more effective than treating the patient in isolation. Because affective lability appears to mediate the path from adversity to suicidal behaviour, emotion-regulation skills should also be a core psychotherapeutic target.^{15,32}

Suicide and Self-harm Risk

The patient displayed several convergent risk markers: severe depression with psychotic features, recurrent NSSI with escalating lethality of means (from urges to cutting with broken glass to picking up a shard with ambiguous intent), command hallucinations, insomnia, hopelessness, recent discharge and interpersonal loss. In a national survey of 1,055 patients with bipolar disorder, more than 40% of those in depressive or mixed episodes reported NSSI, and suicidal ideation was the central symptom bridging self-harm and depression. Longitudinal data indicate that NSSI increases the odds of a subsequent suicide attempt 5.5-fold independent of mental disorders, and in a nationwide outpatient sample the prevalence of suicide attempts was more than seven times higher among patients with NSSI. The discordance between the nursing suicide-risk score of 2 ("low risk") on 8 September and the same-day disclosure of uncontrollable self-harm commands and actual self-injury illustrates the limited predictive value of single scores and the need for formulation-based risk assessment.^{18,19,28}

Command hallucinations deserve specific attention. Among psychiatric inpatients with psychosis, command auditory hallucinations — but not auditory hallucinations in general — were associated with active suicidal ideation and recent suicide attempts. In schizophrenia-spectrum inpatients, 36% of those who experienced command hallucinations for suicide made at least one attempt in response to them; the authors concluded that such hallucinations do not directly predict attempts but raise risk in individuals already at risk, such as prior attempters. Compliance with self-harm commands is predicted by beliefs about future compliance, emotional distress, childhood abuse and substance use disorders. Our patient initially resisted the voices, but by 8 September he described the nocturnal self-harm commands as uncontrollable and had acted on them — a shift that should be interpreted as an escalation of risk warranting intensified observation and treatment.^{20,34,35}

The post-discharge period is a time of exceptional risk. A meta-analysis of 100 studies estimated a pooled post-discharge suicide rate of 484 per 100,000 person-years, rising to 1,132 in the first three months and to 2,078 among patients admitted with suicidal ideas or behaviour; in the first week after discharge the pooled rate reached 2,950 per 100,000 person-years. In a Korean national cohort, outpatient follow-up within seven days of discharge was associated with a lower risk of suicide (hazard ratio 0.82), with benefits across bipolar and depressive disorders. In this case, the first post-discharge review was appropriately scheduled within six days, but after the self-injury on 8 September the next review was set one month later, an interval too long for a patient who had just relapsed; weekly contact, or telephone follow-up, would have been more consistent with the evidence.^{36–38}

Brief, structured interventions reduce suicidal behaviour. In a multisite cohort study, the Safety Planning Intervention with telephone follow-up was associated with 45% fewer suicidal behaviours over six months and more than doubled outpatient treatment engagement; a meta-analysis of safety planning-type interventions found a relative risk of suicidal behaviour of 0.57; and single-encounter acute-care interventions reduced subsequent suicide attempts and tripled linkage to follow-up care. We therefore recommend a written, collaboratively developed safety plan covering warning signs (including the onset of command voices), internal coping strategies, safe

contacts that do not depend exclusively on the partner, professional crisis contacts, and restriction of access to lethal means — including sharp objects and stockpiled medication.^{39–41}

Medication stockpiling is particularly relevant. On 8 September the patient received a 30-day supply that included 60 tablets of lithium carbonate 400 mg (24 g in aggregate) and 60 tablets of olanzapine 10 mg, only days after he had self-escalated his doses and while he reported uncontrollable self-harm commands. Lithium has a narrow therapeutic range — maintenance levels of 0.6–1.0 mEq/L, with toxicity when levels rise much above 1.2 mEq/L — so a large supply represents a significant lethal-means risk in a patient with active suicidal thinking. Limited dispensing (for example, weekly supplies), medication custody by a trusted person and pill counts are pragmatic safeguards, particularly during the first weeks after discharge when risk is highest.^{37,42}

Pharmacological Management of Psychotic Bipolar Depression

The largest network meta-analysis of acute bipolar depression (101 randomised trials; 20,081 participants) found, with moderate confidence, that olanzapine plus fluoxetine, quetiapine, olanzapine, lurasidone, lumateperone, cariprazine and lamotrigine are more efficacious than placebo, and that antidepressants as a class carry a higher risk of manic switch than antipsychotics. For psychotic depression specifically, the combination of a selective serotonin reuptake inhibitor with a second-generation antipsychotic — particularly fluoxetine plus olanzapine — was the only regimen associated with a higher response rate than placebo. CANMAT/ISBD 2018 lists quetiapine, lurasidone plus lithium or divalproex, lithium, lamotrigine, lurasidone and adjunctive lamotrigine as first-line options for bipolar I depression, with olanzapine–fluoxetine as a second-line option. The combination of lithium with olanzapine used in this case is therefore evidence-informed; if psychotic depressive symptoms persist, olanzapine–fluoxetine under mood-stabiliser cover is a rational next step.^{1,43,44}

Two features of the prescribing pattern warrant reflection. First, the antipsychotic was changed twice within nine days (olanzapine → quetiapine → olanzapine) and the quetiapine dose was titrated down to 150 mg/day of an immediate-release formulation before discharge — below the 300 mg/day typically used in bipolar depression trials and well below antipsychotic doses for

psychotic features. Such rapid switching precludes an adequate therapeutic trial, complicates attribution of adverse effects (for example, nausea, vertigo) and may have contributed to early relapse. Second, treatment of bipolar depression remains unsatisfactory even with optimal agents, making it important to maintain a coherent plan with explicit targets, adequate dose and duration before switching. Olanzapine also ranks among the agents most likely to elevate total cholesterol, triglycerides and low-density lipoprotein; the patient's reported persistent hunger and overweight body-mass index at one assessment underline the need for baseline and follow-up metabolic monitoring (weight, waist circumference, fasting glucose or HbA1c, lipids).^{1,45,46}

Retaining lithium is strongly justified. In a meta-analysis of randomised trials, lithium reduced suicides compared with placebo (odds ratio 0.13) and all-cause mortality; within-individual Swedish registry data showed a 14% reduction in suicide-related events during lithium treatment; in a Finnish nationwide cohort of patients hospitalised for bipolar disorder, lithium was associated with a 67% lower risk of suicide mortality, whereas hypnotics were associated with increased risk; and a 2026 meta-analysis of observational studies confirmed lower suicide and suicide-attempt risk with lithium in bipolar disorder. A 2022 meta-analysis restricted to post-2000 randomised trials found the evidence inconclusive, largely because of low event rates, so the anti-suicidal effect should be regarded as probable rather than proven. Lithium also remains the reference agent for relapse prevention in maintenance treatment.^{47–52}

Lithium Safety and Monitoring

Lithium carbonate was increased from 200 mg to 800 mg/day within ten days, the patient self-escalated to 1,200 mg/day, and the regimen coincided with repeated vomiting, bloody diarrhoea, positional vertigo, severe headache and fever — all conditions that may alter lithium absorption and renal clearance. Yet no serum lithium concentration was recorded during either admission or the outpatient period. Maintenance levels between 0.6 and 1.0 mEq/L are generally recommended, levels below 0.6 mEq/L are less effective, and higher levels are associated with more adverse effects and toxicity. Gastrointestinal symptoms and vertigo in this context should prompt an urgent 12-hour trough lithium level, renal function and electrolytes, rather than being attributed solely to anxiety or gastroenteritis.^{42,53}

Beyond acute toxicity, lithium is associated with reduced urinary concentrating ability, hypothyroidism, hyperparathyroidism with increased calcium and weight gain, whereas clinically important reductions in glomerular filtration are uncommon; calcium should be checked before and during treatment. In a predominantly Chinese population, higher mean lithium levels were associated with increased risks of hypothyroidism, hyperthyroidism and chronic kidney disease, with thresholds around 0.5–0.6 mEq/L. Adherence to monitoring guidelines is poor in routine practice: in a Dutch cohort, only 16% of patients were monitored for serum lithium, creatinine and thyroid-stimulating hormone as recommended. We therefore recommend baseline TSH, free T4, calcium, electrocardiography (particularly given concomitant ondansetron and second-generation antipsychotics), a lithium level five to seven days after each dose change and whenever intercurrent illness occurs, and extra vigilance during bowel preparation for colonoscopy, when fluid and electrolyte losses may precipitate toxicity. The radiological report of cardiomegaly on an anteroposterior film, which magnifies the cardiac silhouette, should be verified with a posteroanterior radiograph, electrocardiogram and, if confirmed, echocardiography.^{53–55}

Benzodiazepine Stewardship

The patient first self-medicated with alprazolam, then received it as a scheduled drug, self-escalated to 1.5 mg/day, ran out, and experienced three days of abrupt discontinuation before readmission with marked anxiety, palpitations and insomnia; lorazepam was then introduced on an as-needed basis. In the STEP-BD cohort, benzodiazepine use at remission was associated with a 21% higher risk of mood-episode recurrence. In a Swedish population-based cohort, one in five benzodiazepine initiators with bipolar disorder became long-term users, and those started on alprazolam had twice the odds of long-term use compared with diazepam. Among veterans with bipolar disorder, benzodiazepine prescriptions of 30 days or more were associated with a 58% higher risk of suicide, and in the Finnish cohort hypnotic use was associated with a 52% increase in suicide mortality. Although confounding by indication cannot be excluded, these data argue for time-limited, scheduled rather than open-ended use, avoidance of short-acting high-potency agents where possible, controlled dispensing, a written tapering plan, and early introduction of non-pharmacological anxiety management.^{49,56–58}

The Place of Electroconvulsive Therapy

Electroconvulsive therapy (ECT) is effective in bipolar depression, with a pooled response rate of 77.1% and a remission rate of 52.3%, and with fewer sessions required to achieve response than in unipolar depression. In a propensity-matched Swedish registry study of hospitalised patients with major depressive disorder, ECT was associated with a lower risk of suicide within 12 months, particularly in those with psychotic features (hazard ratio 0.20). For a patient with psychotic bipolar depression, persistent command hallucinations to self-harm, recurrent suicidal behaviour and vomiting that repeatedly compromised oral pharmacotherapy, ECT is a reasonable option to discuss if the current regimen fails to produce a timely response, with appropriate anaesthetic and pharmacological precautions and informed consent.^{59,60}

Somatic Comorbidity and Diagnostic Overshadowing

Diagnostic overshadowing — the misattribution of physical symptoms to mental illness — is recognised as a cause of inferior physical health care for people with mental illness, and emergency clinicians identify complex presentations, communication barriers, crowding and stigmatising attitudes as contributors. The patient's own attribution of nausea and vomiting to anxiety illustrates how easily somatic symptoms may be psychologised. To its credit, the team pursued an organic work-up in parallel with psychiatric treatment through repeated internal medicine co-management, laboratory tests, digital rectal examination and planned colonoscopy. Several aspects of the medical work-up, however, would benefit from refinement, as discussed below.^{21,22}

Fever and the Widal test. The diagnosis of "fever due to bacterial infection" rested on mild leucocytosis and single low-titre agglutinins (1/80) against *S. Paratyphi C* "O" and *S. Paratyphi B* "H". In an Ethiopian study, the Widal test had a sensitivity of 80% but a specificity of only 44.5% and a positive predictive value of 3.8% against culture, and patients were frequently misdiagnosed and treated for enteric fever on the basis of Widal results. A Cochrane review found that even purpose-designed rapid diagnostic tests have only moderate accuracy, with blood or bone-marrow culture remaining the reference standard. Blood cultures should ideally precede empirical ceftriaxone, and a single low titre should not be interpreted as confirming salmonellosis; the

differential diagnosis of prolonged fever with mucosal ulceration and diarrhoea should remain open.^{61,62}

The "hypoglycaemia" label. A random plasma glucose of 78 mg/dL (4.3 mmol/L) in a non-diabetic, asymptomatic young adult lies within the physiological range. The International Hypoglycaemia Study Group considers glucose below 3.0 mmol/L (54 mg/dL) to represent clinically significant hypoglycaemia, and the higher alert threshold of 3.9 mmol/L (70 mg/dL) has itself been criticised as being within the normal fasting range for non-diabetic adults. The administration of a 40% dextrose bolus and a maintenance dextrose infusion was therefore not indicated by the recorded value and could be discontinued, provided oral intake is adequate.^{63,64}

Tranexamic acid for rectal bleeding. In the HALT-IT trial of 12,009 patients with significant upper or lower gastrointestinal bleeding, tranexamic acid did not reduce death due to bleeding (risk ratio 0.99) but increased venous thromboembolic events (risk ratio 1.85). In a haemodynamically stable young man with self-limited haematochezia and a normal haemoglobin of 15.1 g/dL, routine tranexamic acid is not supported by current evidence.⁶⁵

Haematochezia and the rectal mass. Although benign causes (internal haemorrhoid, fibroepithelial polyp, sentinel pile of a fissure, infective or inflammatory proctocolitis) are most likely at this age, early-onset colorectal cancer must be considered. In a systematic review of more than 24 million patients younger than 50 years, haematochezia was present in 45% of those with early-onset colorectal cancer and was associated with at least a five-fold increased risk, and diagnostic delays of four to six months were common. Young-onset colorectal cancer is increasing worldwide and disproportionately affects the rectum. The combination of bloody mucoid diarrhoea, oral ulcers, prolonged fever and a fixed rectal lesion justifies colonoscopy with biopsy, which should be performed promptly and not be delayed by the psychiatric presentation.^{66,67}

Provider-Initiated HIV Testing, the Seroconversion Window and Confidentiality

Offering HIV testing in this context represents good practice rather than stereotyping. In a multisite study of 1,061 people receiving mental health services, HIV prevalence was approximately four times that of the general population, and homosexual or bisexual identity was among the associated characteristics; yet fewer than half of people with serious mental illness have

been tested in the previous year, and providers face ethical challenges in implementing testing in psychiatric settings. Even after sequential quality-improvement interventions increased testing five-fold on an inpatient psychiatry service, 70% of inpatients remained untested. Provider-initiated testing should therefore be offered routinely to all psychiatric inpatients, with informed consent, pre- and post-test counselling, confidentiality and linkage to care, rather than selectively on the basis of sexual orientation.^{23,24,68}

A non-reactive result, however, does not exclude acute HIV infection. The patient's constellation of seven days of fever, oral ulcers, diarrhoea, vomiting and headache resembles primary HIV infection, which classically presents as a glandular-fever-like illness with painful shallow oral, genital or anal ulcers, nausea, vomiting and diarrhoea. Antibody-based tests remain negative during the window period, and lateral-flow point-of-care assays are insensitive for p24 antigen; in one evaluation, a third-generation point-of-care antibody test failed to detect all acute infections, whereas laboratory-based fourth-generation antigen/antibody immunoassays are recommended when acute infection is suspected. If the patient reports a potential exposure in the preceding weeks, a fourth-generation immunoassay or HIV RNA test should be performed and repeated at an appropriate interval, together with syphilis and hepatitis B and C serology and, where eligible, counselling on pre-exposure prophylaxis.^{69–71}

Confidentiality is a further ethical obligation. The patient's sexual orientation is recorded in the medical chart, while his father — who accompanies him and receives psychoeducation — may or may not be aware of it. Inadvertent disclosure ("outing") could provoke family rejection and aggravate the very stressors driving the illness. LGBTQ+ inpatients describe silencing, fear and shame on psychiatric wards. Explicit discussion with the patient about what may be shared with whom, documentation of consent for disclosure, and affirming, non-judgemental language across the multidisciplinary team are essential components of care.^{11,24}

Affirmative, Partner-inclusive Psychoeducation

Adjunctive psychosocial treatment is a cornerstone of bipolar disorder management. In a component network meta-analysis of 39 randomised trials, manualised psychotherapies reduced recurrence (odds ratio 0.56) and psychoeducation with guided practice of illness-management skills

in a family or group format was superior to the same strategies delivered individually. A separate network meta-analysis found that carer-focused interventions were the only psychosocial approach to reduce relapse significantly, and a real-world multicentre study showed that the benefits of psychoeducational family intervention on relapses, hospitalisations and suicide attempts persisted for five years. In the present case, psychoeducation was delivered to the father only; the person whose disbelief precipitated relapse — the partner — was not included.^{72–74}

We therefore propose that "family" be defined inclusively, according to the patient's wishes, to encompass partners and chosen family, with the patient's explicit consent. A structured partner-inclusive programme could address (i) the nature of bipolar disorder and psychotic symptoms, explicitly countering the belief that the illness is feigned; (ii) the impact of criticism and invalidation (expressed emotion) on relapse; (iii) early warning signs, including sleep loss and the re-emergence of voices; (iv) the crisis and safety plan, including lethal-means restriction; and (v) communication and problem-solving skills. This is consistent with evidence that family-focused treatment is most beneficial where expressed emotion is high. Because mental health interventions for sexual-minority people rarely address intersecting forms of disadvantage, and SGM status is seldom assessed in serious mental illness care, clinicians should routinely and respectfully ask about sexual orientation, gender identity and minority stressors, and integrate these into formulation and treatment.^{15,25,26}

Strengths

The strengths of this report include detailed longitudinal documentation across two admissions and an outpatient relapse, multidisciplinary input, and integration of psychodynamic, minority-stress and evidence-based pharmacological perspectives.

Practical Recommendations

Table 7. Summary of recommended actions

Domain	Recommended action
Diagnosis	Confirm prior manic/hypomanic episodes from collateral history and records; assess personality longitudinally in euthymia; measure

	TSH/FT4, calcium
Suicide prevention	Formulation-based risk assessment at every contact; written safety plan; lethal-means counselling (sharpes, medication stockpiles); follow-up within 7 days of discharge and at least weekly thereafter; telephone contact
Antipsychotic	Maintain one agent at an adequate dose and duration before switching; consider olanzapine–fluoxetine under mood-stabiliser cover if psychotic depression persists; metabolic monitoring
Lithium	Trough level 5–7 days after each dose change and during intercurrent GI illness; renal function, electrolytes, TSH, calcium; ECG; caution during bowel preparation; limited dispensing
Benzodiazepines	Time-limited scheduled use; avoid open-ended alprazolam; controlled supply; written taper; CBT-based anxiety and panic management
ECT	Discuss if inadequate response, persistent command hallucinations or inability to tolerate oral medication
Medical work-up	Blood cultures before antibiotics; avoid over-interpreting single Widal titres; discontinue dextrose if not hypoglycaemic; avoid routine tranexamic acid; prompt colonoscopy with biopsy; confirm cardiomegaly with PA film, ECG ± echocardiography
HIV and sexual health	Universal consent-based testing; fourth-generation Ag/Ab or HIV RNA if recent exposure; syphilis and hepatitis serology; PrEP counselling where eligible
Stigma and psychotherapy	Affirmative, confidential care; consent-based partner-inclusive psychoeducation; address expressed emotion; emotion-regulation and minority-stress-informed psychotherapy; link to supportive community resources

CONCLUSION AND RECOMMENDATIONS

Conclusion

This case of a 22-year-old LGBTQ+ man with bipolar affective disorder, current episode severe depression with psychotic symptoms (F31.5), demonstrates how intersectional "double stigma" — minority stress related to sexual identity combined with the stigma of serious mental illness, enacted most painfully through a partner's disbelief in the illness — can interact with early maternal loss, perceived familial invalidation and a biological vulnerability to precipitate command hallucinations, self-injury and two admissions within one month. The patient responded partially to lithium and second-generation antipsychotics with supportive psychotherapy, but relapse was facilitated by frequent antipsychotic switching, medication self-escalation, benzodiazepine dependence and withdrawal, a long follow-up interval and the persistence of the relational stressor. Concurrent fever, vomiting and haematochezia with a rectal mass required parallel medical evaluation in which diagnostic overshadowing was avoided but diagnostic precision could be improved.

Recommendations

(1) Psychotic bipolar depression in SGM patients should be managed with guideline-concordant pharmacotherapy maintained at adequate dose and duration, with lithium retained for its probable anti-suicidal effect and monitored rigorously through serum levels, renal, thyroid and calcium indices and electrocardiography. (2) Every contact should include formulation-based suicide risk assessment, a written safety plan, lethal-means counselling, limited dispensing and follow-up within seven days of discharge. (3) Benzodiazepines should be time-limited, controlled and tapered. (4) Somatic symptoms must be investigated on their own merit — with blood cultures, cautious interpretation of serology, avoidance of unnecessary dextrose and tranexamic acid, prompt colonoscopy and confirmation of radiological findings — to prevent diagnostic overshadowing. (5) HIV testing should be offered universally with consent and counselling, with fourth-generation or RNA testing when acute infection is plausible. (6) Care should be affirmative and confidential, and psychoeducation should include partners and chosen family with the patient's consent, explicitly addressing the invalidation of psychiatric illness. (7) Institutions should routinely and respectfully

34

record SGM status, train staff in affirmative care, and support research on the role of intersectional stigma and partner invalidation in relapse and readmission among people with bipolar disorder in Indonesia.

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