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## **Component 1: supporting paper on bipolar affective disorder**

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### **Introduction**

Bipolar affective disorder is synonymous with bipolar disorder. It is a lifelong chronic mood disorder which leads to intense shifts in mood, energy levels, thinking patterns and behaviour. The extreme mood swing alternates between emotional highs (mania) and lows (depression). These shifts can take place for hours, days, weeks or months and disrupt the victim's ability to perform daily tasks (Humpston, Bebbington and Marwaha 2021).

### **Main body**

Historically, bipolar disorder was previously grouped as "manic-depressive illness" or "manic depression" which covers wider range of mental health illnesses. The shift to "bipolar disorder" offers more clarity in the diagnosis. The commonest risk factor of bipolar disorder is heredity. Also environmental factors such as trauma, stress, drug or alcohol abuse also contribute enhanced risks of bipolar affective disorder. The ICD-10 classified it as F-31.

Recent report indicates that one in every fifty individual is affected by bipolar disorder, implying that 1.3 million people in the UK are suffering from bipolar disorder (Bipolar Facts-UK, 2023). Bipolar affective disorder contributes to increased rate of suicide by twenty percent, with at least 800 bipolar disorder patient taking their lives yearly in the UK. The commonest symptom of bipolar affective disorder is the experience of alternating episodes of hypomania, mania, and depression. Hypomania is not strictly the same to mania because it has milder symptoms. Hypomania episodes is more manageable though it still exhibits significant negative impact on the day-to-day activities of the individual. Hypomania occurs for shorter durations. Manic episodes are characterised by not less than seven days of deep mood disturbance which features being highly elated, irritability, or expansiveness. Other symptoms of the mania phase are: (i) having lots of energy, including high ambitions and ideas, (ii) spending money extravagantly, (iii) decreased feeling for sleep or eating, and (iv) excessive talking or pressured speech (NHS Treatment - Bipolar disorder). Additionally, one may experience symptoms of psychosis, where one sees or hears imaginary/unreal things or easily gets convinced of vague or unreal feelings. Features of depressive episodes usually lasts for about two weeks and they include: (i) depressed mood, (ii) significantly reduced interest or pleasure in almost every activity, (iii) noticeable weight gain or loss, including substantial increase or loss in appetite, hypersomnia, (iv) insomnia or (v) reduced physical activity, (vi) tiredness, and (vii) suicidal thought or suicidal attempt.

Different types of bipolar affective disorder include: (i) Bipolar 1 disorder. In this case, the individual experience a minimum of one episode of mania that will last at least one week. The duration of the mania can extend from three to six months if not treated, while depression could persist for between six to 12 months. (ii) Bipolar 2 disorder. This is characterised by mix of hypomania and depression. (iii) Cyclothymic disorder or cyclothymia. This is when the individual experiences regular episode of depression and hypomania for more than two years. (iv) Mixed bipolar state. This means when the individual experiences mania and depression simultaneously. (v) Rapid cycling bipolar. This is when an individual has a combination of depressive, manic, mixed, or hypomanic episodes within 12 months. The changes from mania to depression could be daily, weekly, or monthly.

Diagnosis of bipolar affective disorder is mostly misdiagnosed. Humpston, Bebbington and Marwaha (2021) argue that it takes a mean of nine and half years to obtain an accurate diagnosis of bipolar disorder. The reason for this long duration of diagnosis is because at the onset, bipolar disorder display different symptoms for different people, and the symptoms also varies over time. Diagnosis of clinical depression before a manic episode are common in people with bipolar disorder, hence a specialist assessment is always necessary. The

assessment will be done by a psychiatrist and typically include the symptoms the individual has been experiencing, including how long it has lasted. The psychiatrist will also inquire how the individual feels during and after the fluctuating episode of mania or depression, including if the individual engages in suicidal thought or self-harm. The psychiatrist will ask about the previous medical and family background of the patient to know if any of the relatives had bipolar affective disorder.

Bipolar affective disorder is treated with combination of different options through medication, psychological treatment (therapies), self-management therapy, and change in lifestyles. Treatment for bipolar affective disorder in the UK include: (i) Mood stabilisers such as lithium, anticonvulsant medicine, and antipsychotic medicines (NHS Treatment - Bipolar disorder). For teenagers with bipolar disorder in the UK, lithium and the antipsychotic medicine such as aripiprazole are used. Anticonvulsant medicines (lamotrigine, valproate, and carbamazepine,) are also used to treat mania episodes, and they serve as long-term mood stabilisers. Mania episodes in bipolar disorder are also treated with antipsychotic medicines such as, quetiapine, risperidone, haloperidol, and olanzapine. They are all used as a long-term mood stabiliser, while Quetiapine has added advantage for use in long-term bipolar depression. Depression episodes in bipolar disorder are treated relatively different because the use of antidepressants provokes relapse.

Psychological treatment (psychotherapy or talk therapy) includes variety of treatment approaches which aims to assist individuals with bipolar disorder to identify and change troubling emotions, thoughts and behaviors. Such therapies are social rhythm therapy amongst, cognitive behavioural therapy, interpersonal, and family-focused therapy amongst others. Successful treatments can be enhanced through: (i) self-management strategies (education and identification of early signs of an episode or possible triggers of episodes), and (ii) useful lifestyle habits. Other treatment options are electroconvulsive therapy, thyroid medication, ketamine treatment, transcranial magnetic stimulation, and hospitalisation.

These options have all shown positive outcomes. The negative consequences are mostly from the side effects of taking the medications (lithium and the antipsychotic medicine, anticonvulsant, and antidepressants). These side effect vary for different individuals (Muench and Hamer, 2010). In the UK, individuals with bipolar disorder lack the treatment and basic support needed to live well with the condition. About 67% of individuals with bipolar disorder did not get self-management advice during their initial diagnosis (Bipolar Facts-UK, 2023). Individuals with bipolar disorder have experienced abuse in hospital and are dealing with undiagnosed post-traumatic stress and stigma. Professionals working with individuals with

bipolar disorder should use person-centred care. The Mental Health Act (2007) is the guiding legislation for professionals that supports their treatment.

## **Conclusion**

Bipolar affective disorder is amongst the mood disorder that is recognised as a mental health problem by the ICD-10 and classified under F-31. The prevalence in the UK, diagnosis, different treatment options and their implications, including support and legislation are x-rayed.

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