

University of Wales Trinity Saint David

Mental Disorders and Psychopathology

Assessment 1

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Introduction

The society is facing various health problems due to different factors that affect the standard of life and nowadays mood disorders are a pressing problem world wide. Depression alone is a concerning disorder which has been taken into consideration in contrast with the past neglect.

This report assess the bipolar disorder by presenting an overview of the illness, looking at how is diagnosed, how was treated in the past and how is treated currently.

Definition

Bipolar disorder is a chronic condition that is characterised by extreme mood swings which can include episodes of mania, depression, hypomania and other mixed affective states. The bipolar disorder can present extreme high form such as mania and extreme lows such as depression. The disorder is affecting a low percentage of the population 5% but is among one of the top causes of disability for young persons up to 40years old and a suicide rate of 10-20% which gives high morbidity and mortality (DeRubeis, 2015).

Causes

It is widely acknowledged that the bipolar disorder is the result of chemical imbalances in the brain. Evidence suggests that episodes of mania are determined when levels of noradrenaline are too high and episodes of depression when the noradrenaline levels are too low (NHS, 2022).

There are different causes for the bipolar disorder such as genetics and triggers. According to DeRubeis (2015) heritability is a large percentage over 60% for having this disorder, being a polygenic disorder. Studies has been identified that genetics are also susceptible for other disorders such as schizophrenia and attention deficit disorder. That is why sometimes families get tested in order to check the genetic risk for bipolar disorder. Some people even might decide not to have children when the genetic risk is considered to be too high, although DNA test is not a definitive result. Triggers for the bipolar disorder can be in the form of a stressful situation faced by the individual at one point such as physical or emotional abuse, breakdown of a relationship, death of someone loved, physical illness, continuous lack of sleep, life difficulties that are overwhelming.

Symptoms/signs

The Bipolar disorder can involve major depressive episodes, manic episodes, irritable mood that lasts, as well as hypomanic. Psychotic features are affecting the mood and can manifest as delusions such as having an overestimating view over personal qualities. Despite that many times the bipolar disorder is unrecognised (NHS, 2022).

Diagnosis

Diagnosing the bipolar disorder is realised based on the mania alone even if the patient more often has a history of past and current depressions. The bipolar disorder is diagnosed in hospital when the patient is admitted for mania. Not many clinicians are very familiar with hypomania either and fail to detect it. The disorder is associated with major depressions but it involves having also other key symptoms for a longer period of time. Depression is the main cause for suicide because of the functional impairment that patients can not cope with. Marked psychomotor retardation is more common, together with psychotic depression in younger people and atypical features of depression, such as hypersomnia. This type of patients will lack any motivation to do anything and will have extreme loss of energy. Usually a bipolar depression suggests a bipolar disorder diagnose.

In medicine is much more difficult to diagnose such disorders as is not that obvious like in acute infections. Currently less severe manifestations of mood elevation and depression are now also thought to merit recognition as bipolar disorder. It includes recurrent subthreshold hypomania in the presence of intercurrent major depression, recurrent hypomania (at least two episodes) in the absence of recurrent major depression with or without subthreshold major depression, recurrent subthreshold hypomania in the absence of intercurrent major depression with or without subthreshold major depression.

The risk of bipolar disorder related to the genetic inheritance is much more likely to be diagnosed earlier of 6% rather than 0.5% for the rest of population. Through continuous research and more complex genetic analysis it is performed a more detailed analysis of this genes and larger samples are scanned for more reasonable results. Statistics highlight that the higher risk and the association with bipolar disorder are the genes coding for ankyrin G and the alpha chain of L-type calcium channels (Barnhill, 2012).

The diagnosis of the bipolar disorder can be controversial when it has to be established the boundary of hypomania with what is considered to be normal and number of episodes, intensity and association with other morbidity such as substance mis-use, self harm and depression.

The traditional consideration on the start of bipolar disorder is after the patient has been hospitalised for a few months. In contrast the the new alternatives of early diagnosis consider the sum of chronic mixed features of the prepubertal bipolar disorder. That is why the numbers of very young patients with bipolar disorder has increased lately.

Historical view and treatments

Historically the bipolar disorder was known as the manic disorder. It is mentioned since the antiquity by the Greek clinicians who identified patients with euphoria and psychosis represented by manic states and suicidal and despair for melancholia which today is represented through depression.

In the late part of the 19th century Emil Kraepelin has distinguished the “manic-depressive insanity from the other forms of functional psychosis by analysing patients at the asylum he worked. He observed that in contrast with other forms, bipolar disorder patient can recover with treatment and that is the way forward (Barnhill, 2012).

Despite that the bipolar term is quite modern starting to be used after the 1960's and makes distinction between patient with both mix of moods, elevation and depression. The research and studies from the last 2 decades have contributed to the understanding of the disorder and the recognition and treatment of psychiatric disorders have registered advancement. Nowadays the bipolar disorder is not considered to be a rare disorder there are addressed the mild ranges of the disorder too and the treatment has been improved with new classes of medicine being proposed and used (Table1). The approach of the treatment is also different involving the patient in the disorder's management, through educative relation with the doctors..

Mania was treated with antipsychotic medication such as chlorpromazine which was also used for schizophrenia. By sedating the patients it has been observed side effects and other complications from motor side effects and other severe effects from the high doses used. The results of sedation was that patient would drop out and would not need nursing attention and therefore had a pragmatic application.

Table 1. Introduction of Mood Stabilizers for the Treatment of Bipolar Disorder

	Name of Drug	Period of Fulfilling Criteria for MSs
First-generation MSs	Lithium <i>Anticonvulsants</i> : valproate, carbamazepine	1963, turn of 1960s/1970s , early 1970s
Second-generation MSs	<i>Atypical antipsychotics</i> : clozapine, olanzapine, quetiapine, aripiprazole, risperidone <i>Anticonvulsants</i> : lamotrigine	1995, turn of 1990s/2000s , early 2000s, 2007, 2010, early 2000s
Drugs that have not fulfilled the criteria for MSs or pending for inclusion into second-generation MSs	<i>Atypical antipsychotics</i> : asenapine, lurasidone, ziprasidone <i>Anticonvulsants</i> : gabapentin, topiramate	

Current treatments

The treatment for the bipolar disorder addresses different stages acute manic episodes, acute depressive episodes, and the prevention role for recurrent affective episodes of manic and depression.

The treatment of the bipolar disorder is on long term and on indefinite term because it has the purpose of preventing the recurrence of new episodes and ensuring the highest quality life possible. The short term treatments only address the treatment of the episodes. Specific treatment is available for mania and mixed states and it is recommended to ensure a reduced stimuli environment. The antipsychotic treatment for mania which is a

hyperdopaminergic state ensured a blockade of dopamine receptors which is identified as the appropriate approach to treatment. Atypical antipsychotics can be used in trial such as aripiprazole, olanzapine, quetiapine, risperidone and ziprasidone, the last one not being licensed in the United Kingdom. The use of Asenapine is a new method to because of the administration mode. Lithium monotherapy is used for the treatment of less severe manic states. When the episodes of manic are recurrent it is also added and antipsychotic to the treatment. The strategy for the treatment of mania is to reduce and control the behavioural disturbance when the episodes occur and tho shorten them (Bhagwagar , Goodwin, 2002). Clinicians should also consider on the long term the risk of switching from mania to depression and the risk should be avoided through treatment. That is why mixed states are more difficult to treat and can take longer. The lack of studies also reduces the knowledge on the treatment and it has been observed that atypical antipsychotics function better. The use of antidepressants for example fluoxetine, olanzapine is more embraced nowadays, but it the past was neglected the treatment for depressive episodes for the patients with bipolar disorder is very important because it has been observed that it can last longer than the other states. There are not many studies and vast data available regarding the bipolar disorder and the efficiency of the antidepressants and place had similar results with medicine given. In general when antidepressants are part of the treatment for bipolar disorder, there is used together with an antipsychotic to reduce the risk of mania (Gijsman, 2004).

Anticonvulsants are part of the treatment for the bipolar disorder being used in acute depression as it is suggested that can be stabilising the patient's mood and does not influence the risk of switching to a manic state (Peet, 1994).

Mania can emerge following depression in the cases when treatment does not have a propensity, but is not known if the real cause was the drug treatment. Lack of studies on this does not help clinicians to establish the probability o switching and that is why is recommended the usage of and antigenic agent together with antidepressants. Treating depression can be challenging as it can become a long term problem and medical treatment should be offered considering long treatment too. Quetiapine and lamotrigine is usually the first-line interventions based on the improvement and prevention of relapse. Antidepressants may be discontinued when the patient develop mania (Goodwin, 2003).

Electroconvulsive therapy is a treatment that can be used in pregnancy and can help with severe depression, mania or mixed states (Mukherjee et al, 1994).

Principles when working with people with bipolar disorder

It is considered that the care given to the patients with bipolar disorder is not optimal and many times there is a lack of communication between doctor and patient in order to have the most efficient therapeutic results. The treatment of this complex chronic condition can register positive results if the patient assumes a self management role or has continuous support from family and friends and clinicians use a systematic approach that considers each individual's needs.

The purpose is to increase the quality of the life of the patient through agreeing on the best management of the disorder. Patients can be taught how to monitor and identify symptoms and have a management plan decided by the doctor. Symptoms such as sleep disturbance can be easily monitored and addressed with early treatment and that can be realised through patient autonomy and self management. It is very important that alcohol and drugs are not used at all in order for the plan to function. This approach allows immediate action and faster results to treat the disorder. Therefore the clinicians will have to obtain knowledge on each patient from family history to previous treatment response, and will need the knowledge on the treatment guideline and proven treatments (Schneck et al., 2008).

Recommendations and conclusion

The report has highlighted the complexity of this chronic disorder which affects the population. It has been evaluated that in the recognition of the disorder has been distinguished late from the other forms psychiatric disorders and treatment has not been observed for large size samples for many areas.

It is recommended that more studies are undertaken in order to have more details in relation to the most efficient treatment for the states of the patient. It is also recommended to ensure that clinicians have better knowledge in diagnosis in early stages the bipolar disorder.

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ASSESSMENT COMPONENT 1 MENTAL DISORDERS AND PSYCHOPATHOLOGY

BIPOLAR DISORDER

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BIPOLAR DISORDER WITHIN THE ICD-10 MANUAL

- GROUP :MOOD [AFFECTIVE]DISORDER (F30-F39).
- CLASSIFICATION : F31 BIPOLAR AFFECTIVE DISORDER

BIPOLAR DISORDER DEFINITION

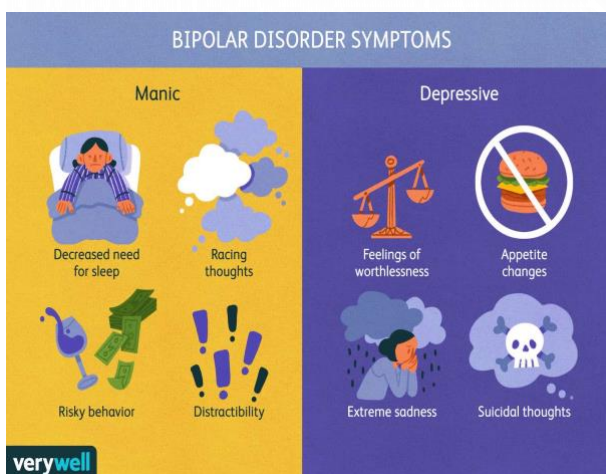
- Bipolar disorder is a chronic condition that is characterised by extreme mood swings .
- The bipolar disorder can present extreme high form such as mania and extreme lows such as depression (DeRubeis, 2015).



CAUSES

- The exact cause of bipolar disorder is unknown
- Chemical imbalance in the brain
- Genetics: According to DeRubeis (2015) heritability is a large percentage over 60% for having this disorder, being a polygenic disorder.
- Triggers:-physical or emotional abuse
 - breakdown of a relationship
 - death of someone loved
 - continuous lack of sleep
 - life difficulties that are overwhelming (NHS, 2022).

SYMPTOMS/SIGNS



- The Bipolar disorder can involve major depressive episodes, manic episodes, irritable mood that lasts, as well as hypomanic.
- Psychotic features are affecting the mood and can manifest as delusions such as having an overestimating view over personal qualities.
- Despite that many times the bipolar disorder is unrecognised (NHS, 2022).

DIAGNOSIS

- Diagnosis based on mania alone prevails
- Not many clinicians are very familiar with hypomania and fail to detect it.
- The disorder is associated with major depressions but it involves having also other key symptoms for a longer period of time
- The traditional consideration on the start of bipolar disorder is after the patient has been hospitalised for a few months
- Currently less severe manifestations of mood elevation and depression are now also thought to merit recognition as bipolar disorder (Barnhill, 2012).

HISTORICAL VIEW AND TREATMENTS

- Historically the bipolar disorder was known as the manic disorder
- In the 19th century Emil Kraepelin has distinguished the “manic-depressive insanity” from the other forms of functional psychosis
- The bipolar term is quite modern starting to be used after the 1960’s and makes distinction between patient with both mix of moods, elevation and depression.
- Mania was treated with antipsychotic medication such as chlorpromazine which was also used for schizophrenia. By sedating the patients it has been observed side effects and other complications from motor side effects and other severe effects from the high doses used.

CURRENT TREATMENTS

- The treatment of the bipolar disorder is on long term and on indefinite term.
- The short term treatments only address the treatment of the episodes
- Mixed states are more difficult to treat and can take longer
- The treatment can include: electroconvulsive therapy, antidepressants, anticonvulsants, antipsychotics, atypical antipsychotics (Goodwin, 2003).

PRINCIPLES WHEN WORKING WITH PEOPLE WITH BIPOLAR DISORDER

- Obtaining knowledge about each individual patient regarding family history, response to treatment etc.
- Management of the disorder on the long term
- Patient to assume autonomy and self management (Schneck et al., 2008).



RECOMMENDATIONS AND CONCLUSION

- It is recommended that more studies are undertaken in order to have more details in relation to the most efficient treatment for the states of the patient.
- It is also recommended to ensure that clinicians have better knowledge in diagnosis in early stages the bipolar disorder.



REFERENCES

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