**Etiology and Evidence Base Treatment Approach Utilized For Bipolar Disorder**

**Introduction**

The aim of this study is to assess the diagnosis and treatment of approaches to particular mood disorders, bipolar disorder with the overall objective of learning about the diagnosis and treatment of bipolar disorder. Additionally, the study investigates how well people can do after getting the treatment they need at psychiatry.

**Overview of Bipolar Disorder**

There is one category in which patients have just episodes of depression that come and go while in another category that indicates episodes of depression and these episodes alternate with highs and with mood swings are different requiring different treatments for varying patients. The main thing to consider when it comes to how bipolar disorder presents itself is that it develops during childhood in adolescents and young adults and 50% of society members have the onset of this illness by the age of 14 and 75% by the age of 24 (National Collaborating Centre for Mental Health, 2006). Bipolar disorder most commonly develops with periods of depression, where a patient has symptoms like periods of increased physical energy, increased sexual energy, racing thoughts, speech that goes fast, and most importantly impulsiveness including execution of activities quickly without thinking about the consequences.

**Etiology of Bipolar Disorder**

The psychological perspective and abnormal behavior arises from several different approaches such as psychoanalytic behavioral. The first specific causes of bipolar are related to psychodynamic theory for a conceptualized depression and anger turned inward as a result of the lows of the condition. Whether real or imagined, psychodynamic theories also interpret the media hypomania bipolar disorder as one way to protect or defend oneself from the experience of depression. The Sheldon Silver linings playbook is an example of a depiction of people experiencing loss of their romantic relationships and exhibit symptoms of bipolar disorder. (Simsion, 2015).

The second specific causes are related to attachment theory. Studies indicate that relationships cause depressive episodes based on the onset of any damage or destruction. This relationship may lead to depression and anxiety (Perlis et al. 2004). The third specific causes related to behavior carries Petersburg operant conditioning, specifically with reinforcer playing a role in depression-scale, hypothesizes that depression may result from the withdrawal of reinforcement for those healthy behaviors and will positively reinforce to engage in social and relationship-building behaviors leading to the prevention of depression (Kilbourne, 2004).

The fourth specific causes related to learning and modeling for enslavement about the. learned helplessness to explain how individuals develop avoidance-learning statement such as “my significant other broke up with me because I’m unlovable and I will always be unlovable” attribute the situation to an internal cause that is personal and pervasive. This type of education may lead to feelings of helplessness, hopelessness and depression. The sound of urgency recites an example of how learned helplessness impacts the lives of those with restricted privileges. The second specific causes related to cognitive theory and Verchick (2016) hypothesized that negative thoughts cause depressive feelings and behaviors. These negative cognitive schemas became so ingrained in an individual’s personality that mood swings and severe depression take course.

After many years of arguing and disagreeing among the psychiatric community as to how to conceptualize the PSM 5, the overall movement in DSM five was to move from descriptive approaches to assessing what underlies disorders, to capture and describe them. Evidence-based approach in this regard would be utilized in the form of data from genetic, imaging studies, and other kinds of analyses of the brain to characterize psychiatric disorder. In order to have bipolar disorder, one has to have mania and only one manic episode for many years still shows bipolar development or presence (Viktorin et al, 2014). For proper diagnosis of bipolar disorder, a patient must have a history of at least one manic episode. In order to have bipolar disorder, bipolar 1, one will experience abnormally persistently, elevated, expansive, or irritable mood that lasts for at least a week or until a professional intervention.

**Depression and BD**

In today’s society where one is exposed to one concern of why individuals become depressed and what can be done about it. Depression is often portrayed as a malfunction in the brain and the number treatment or intervention is the prescription of antidepressants, depression, according to studies, is an illness or refers to the same underlying disorder, major depressive disorder, which gives the impression that one depression case and another are instances of the same thing. However, it is observed that to be depressed often entails many of the same unpleasant signs or symptoms. The reasons for the development of depression in varying cases are often buried in various specific conditions relevant to an individual’s lifestyles instead of just focusing on the symptoms of depression.

According to significant gaps in research, there existed minimal recognition of Bipolar one this spectrum disorders as the condition has not been clinically been diagnosed frequently and accounts for about 1% (Verchick, 2016). Verchick (2016) argues that there are unipolar depressions that are part of the bipolar spectrum because they cycle where mood disorders cycle. However, these unipolar cases are at per with cyclothymic conditions as they do not cycle to mania. In this regard, evidence-based treatments struggle with identifying what supports the concept of a bipolar spectrum disorder.

**Diagnosis of BD**

Bipolar disorder, in contrast to many other types of hypomania of depression is difference in terms treatment. The reason why this is a problem is that up before until one starts having the mood swings, few realize it is really bipolar disorder which is important because the treatment is different from other forms of depressive behavior. The treatment for patients who had major depressive disorder is a traditional antidepressant when it comes to bipolar disorder. Studies show that the foundation for treatment isn’t antidepressant and required intervention should be mood stabilizer which is an important requirement to get this right during evidence-based approaches in treatment. One of the most unique clinical findings about bipolar disorder is that more often it is misdiagnosed and treated as if it’s just major depressive disorder treatment; major depressive disorder treatment is different than the treatment for bipolar disorder (Moreno, et al, 2007).

The diagnosis of a major depressive episode, bipolar disorder or unipolar major depressive disorder, is basically the same. The symptoms of major depression are the same during major depressions. Patients can be emotionally unstable like portraying signs of sadness or be less interested in doing routinely duties. On the contrary, some cases showcase more active behavior where others experience increased need to rest.

The diagnosis of bipolar disorder is considered to be challenging. The key difference is that in bipolar disorder, patients have depressions mingled with having mood swings. In this case, clinicians and medical professionals cannot make a bipolar disorder diagnosis based on particular type of depression. Severe mood swings and mild mood swing are termed as hypomania which have similar symptoms, but are overall very mild such that they result in no impairment. Specific observable behavior changes include significant change in behavior where a sufferer can result in very hype behavior while on the other hand, a patient will portray signs of easily agitated, restless, and depressed all showcasing depression-like behavior regardless of the conditions adding up to mania.

The key symptoms of bipolar include difficulty controlling how much a patient worries about things ending up getting excessively anxious about upcoming events. These are the two important symptoms of generalized anxiety disorder. With specifics such as panic disorder, an individual has intense onset of lasting from 5, 10, and 15 minutes. In addition, physical symptoms include palpitations and difficulty sleeping, stomach upsets, and difficulty swallowing are all symptoms of panic disorder. For wrongly diagnosed patients, some receive Valium for treatment of the condition-related symptoms. For this situation, clinical studies recommend a mood stabilizer (Su, et al. 2004).

Without professional intervention, the use of non-evidence-based approaches such as the use of antidepressants does not resolve the underlying issues. It is considered rather irrational to label oneself as having major depressive disorder and focusing on treating the symptoms. Thus approach does not deliver reliable evidence-based intervention. The complex life issues and internal struggles are considered the root of individual depression. In order for one to be truly understanding and work through feelings and experiences that are causing depression, it is recommended that the services of a psychodynamic therapist be sought. Psychodynamic therapy focuses not only on approaches and strategies to help in combating the symptoms of depression, but it also helps in the discovery of the root causes of depression by analyzing and understanding influencing past events that have shaped a patient to a person with specific vulnerabilities and developing of specific ways of protecting the patient.

The typical symptoms of manic behavior leading to bipolar diagnosis are the inflated self-esteem, grandiosity, decreased need for sleep, more talkative than usual or pressure to keep talking like insomnia, daily, hypersomnia, psychomotor agitation, retardation, daily flight of ideas. Some behavior-based symptoms that practitioners assess initially include the ability to talk skipping over different topics in on the space of a few sentences, increase in goal directed activity; sometimes very productively and sometimes very disorganized, excessive involvement in pleasurable activities.

**Treatment of BD**

Just because a patient is bipolar positive, studies indicate that cases can be sustainably productive. Examples of bipolar-positive people in history include the likes of Abraham Lincoln, Isaac Newton, and Winston Churchill to mention some recorded cases in history.  For convulsive therapy ECT is a modality that works for treatment of very severe depression (Goldstein, et al. 2009). ECT is an abbreviation for electroconvulsive therapy and when medium seizures are considered antidepressant efficacy subset of ECT. In this case, a patient is treated in a clinical setting such as a hospital where anesthesiologist administers anesthesia inducing sleep and an induction of a seizure is electrically administered immediately. Patients can be subjected to this treatment up to 3 times a week such as on Mondays, Wednesdays and Fridays for a period of several weeks. Upon the subjection of treatment for 6 to 12 treatments, the depression episodes heal fully based on the individual response rates for ECT. ECT has a high response rates for subjects with really severe depression and therefore it is a reasonable consideration for cases with severe bipolar symptoms treat bipolar disorder.

**Evidence Based Intervention**

Some causes of bipolar behavior are grossly engraved on substance use causing disorders related to the induced substances. On the one hand, users will abuse the substance such as hard drugs while, on the other hand, cases create dependence which develops to abuse that leads to impairment, interruption of work life, dissociation from family or social life. Dependence results when somebody uses substances over lengthy period resulting in the development of tolerance to the substance such that it has less effect from the same quantity and influencing more intake to influence the same effect. For bipolar subjects, use of substances is more severe at the withdrawal stage where symptoms relate to the co-occurrence of either abuse or dependence.

A variety of studies include the importance of family suggesting that individuals who do not have their family close by can suffer from severe outcomes if they are identified early as it is likely that the case would be diagnosed right away. Family involvement at the time of the initial assessment is important for two reasons. One, people benefit from having the support of family present at the initial assessment tool. Sometimes people don’t know they have the symptoms of mood swings and the family can help with this. It’s very difficult to get a history about the highs of the condition. This is when you really need the family involved, especially for a case that’s been productive and employed in achievement oriented career. One of the unique findings about psychiatric illness is that it’s unusual for psychiatric illness to present by itself; with just one example. As a result, this is particularly important in bipolar disorder because the vast majority, 98-99% of people who have bipolar disorder will have another related illness such as alcoholism (American Psychiatric Association, 2002).

Studies suggest that medical personal responding to bipolar cases should consider asking about alcohol abuse, drug abuse, and any other third most common co-occurring illness. This is a generalized anxiety disorder which involves feeling anxious most of the time and thinking about suicide due to feeling down, depressed, and hopeless. However, it is the presence of a problem without diagnosis or onset of anxiety which can make a patient who is thinking about depression to make plans to attempt suicide. The anxiety coupled with related illnesses convert the suicide thoughts to actual planning and attempting suicide (Goodwin et al. 2003). As a result, evidence-based intervention must account for the other co-occurring illnesses which have adverse motivation towards self-harm.

While diagnosis for bipolar is focused on the timeframe of influencing factors, manic behavior that isn’t supported by any frameworks or timeframes  fall into the broad category of bipolar NOS, not otherwise specified, which does not fit the categories that are described. As a result, hypomania is characteristic of bipolar two, where a sufferer can have hypomania but does not meet the criteria for bipolar two. For instance, an individual who suffers a day or two of hypomania, the case does not meet the criteria for bipolar 2 leading to a brief hypomania (Dickstein, et al. 2015). Hypomania like that of bipolar 2 is a commonly understood reference that and individual gets hypomania and also depression this combination is more characteristic of bipolar two. In order to be rigorous in the clinical setting, the above diagnoses are in the PSM and a practitioner must identify the correct match between the condition and the underlying symptoms as influenced by time, genetics, and other forms of relevant data (Olfson, et al. 2014).

As earlier stated, NOS cyclothymic disorder is a combination of mild mania and depression that cycles and then mood disorder not otherwise specified. If it doesn’t really use them all into the bipolar disorder, unspecified out if you look in other diagnostic systems like the ICD-9, you can find other categories of bipolar disorder (Simsion, 2015). For instance, hyperthymic personality describes an individual who is always the ‘little man’ and does not cycle. The individual stays at a level of same degree of mania all the time while and is referred as hyperthymic personality as described by the ICD-9. The ICD-9 uses language persistent with hypomania personality and is classified under the personality disorders which indicate how confused the diagnostic system is because in the bipolar spectrum, cyclothymic disorder should be in the bipolar disorders (Calabrese, & Delucchi, 1990). However, because it is a steady style of relating, ICD-9 puts it in the personality disorders but rapid cycling bipolar disorder is not mentioned in the PSM. In fact, according to studies, there are a couple of cases where individuals condition cycles of their bipolar disorder mania and depression are rapid and down and are not captured in the DSM. These cases fall into NOS category pointing out that bipolar disorder is widely prevalent. So under the DSM, the rate of bipolar 1 disorder is approximately about 1/100 (Post, 2017).

In terms of evidence assessment and analysis, given the presence of common genes as influenced by family histories, where relatives of people with mild bipolar disorders have relatives still having bipolar disorder. The consideration of imaging studies that support analysis of treatments accounts for the axis of severity indicating that bipolar 1 has a schizoaffective disorder such that bipolar with psychotic symptoms is less prevalent at 1%.

**Conclusion**

The aim of this study has been to assess the diagnosis and treatment of approaches to particular mood disorders, bipolar disorder with the overall objective of learning about the diagnosis and treatment of bipolar disorder. Findings show that bipolar disorder develops during childhood in adolescents and young adults and 50% of society members have the onset of this illness by the age of 14 and 75% by the age of 24. The findings also indicate that relationships cause depressive episodes based on the onset of termination or damage. The first specific causes of bipolar are related to psychodynamic theory for a conceptualized depression and anger turned inward as a result of the lows of the condition. Petersburg operant conditioning has been identified as a theoretical framework showcasing how relationships and support prevent the onset of bipolar by stating that reinforcer plays a role in depression-scale and that depression may result from the withdrawal of reinforcement for that healthy behavior.

Clinical findings about bipolar disorder show that the condition is misdiagnosed and treated as if it is just major depressive disorder treatment; major depressive disorder treatment is different than the treatment for bipolar disorder and its diagnosis is considered to be challenging. Observed differences in patients show depressions mingled with having mood swings while others do not have cycling episodes. For evidence-based treatment, clinicians and medical professionals cannot make a bipolar disorder diagnosis based on the analysis of one type of disorders and therefore, background data is needed. Severe mood swings and mild mood swing are termed as hypomania which have similar symptoms, but are overall very mild such that they result in no impairment. These differences present a challenge to the practitioners as they can be treated as severe cases.

The downsides of non-evidence-based approaches such as the use of antidepressants does is that it does not resolve the underlying issues and is considered rather irrational to label oneself as having major depressive disorder and focusing on treating the symptoms without analysis of the causes.

A variety of studies include the importance of family suggesting that individuals who do not have their family close by can suffer from severe outcomes if they are identified early as it is likely that the case would be diagnosed right away. Family involvement at the time of the initial assessment is important for two reasons

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