

Bipolar Disorder: Historical and Contemporary Medical Approaches

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Abstract : *There has been recent research, including that in highly regarded journals such as Journal of American Medical Association (JAMA), which questions the benefit of doctors and the medical profession and whether they may in fact represent a significant cause of harm to patients and, furthermore, that the medical profession needs to continue to strive toward further development and evolution. This report focuses attention on manic-depressive illness and consideration of the future in respect of its conceptualisation and treatment. The fact that hypomania, cyclothymic disorder and other manic-depressive states (extending to perhaps mania) may in some circumstances represent a performance advantage should certainly be taken into account and it ensured that medical professionals are not hindering a person's performance and quality of life and controls implemented adequately to ensure there is objective and subjective benefit to any course of treatment offered to patients.*

The history of bipolar, or manic-depressive illness generally, stems back to 1st century Greece and Rome where the terms 'mania' and 'melancholy' are felt to have originated, the terms more commonly known contemporarily as manic and depressive states (Sadock and Ruiz, 2009; Krans and Cherney, 2016). The practice of psychiatry was then consolidated by perhaps the most prominent (or, one of the most prominent) psychiatrists - Austrian psychiatrist Sigmund Freud (1856 - 1939) who conceptualised psychiatric illness based on foundations of psychoanalytical theory. A shift in the conceptualisation of bipolar occurred with German psychiatrist Emil Kraepelin who departed significantly from Freudian psychoanalytical theory toward a biological model of illness (Sadock and Ruiz, 2009; Krans and Cherney, 2016; Malhi, 2009; Severus, 2013).

Current medical diagnostics, according to DSM-V, considers manic-depressive illness to span cyclothymic disorder through bipolar disorder (APA, 2013). Further, bipolar disorder is considered to comprise a number of subgroups the two main being Bipolar Type 1 and Bipolar Type 2 (Angst, 2013; Bloch and Singh, 2007; APA, 2013;

Sadock and Ruiz, 2009; Semple and Smyth, 2013). In brief, the criteria for a diagnosis of Bipolar Disorder Type 1: "At least one manic or mixed episode, but there may be episodes of hypomania or major depression," the criteria for Bipolar Disorder Type 2: "the diagnosis of this bipolar disorder requires neither a manic or mixed episode, but does require at least one episode of hypomania in addition to at least one episode of major depression," and, the criteria for Cyclothymic Disorder: "diagnosis of cyclothymic disorder requires a history of multiple hypomanic episodes intertwined with multiple episodes of depression that do not meet the threshold for major depression" (APA, 2013; Sadock and Ruiz, 2009). Treatment, in brief, comprises mood stabilization (most commonly medication based) in addition to, where appropriate, adjunct antipsychotic, antidepressant and anxiolytic therapy (APA, 2013; Joyce, K., Thompson, A., Marwaha, S., 2016; Sadock and Ruiz, 2009; Sophie et. al. 2016; Talley and O'Connor, 2014; Yuen, 2016).

There has been recent research, including that in highly regarded journals such as Journal of American Medical Association (JAMA) which question the benefit of doctors and the medical profession and whether they may in fact represent a significant cause of harm to patients and, furthermore, that the medical profession needs to continue to strive toward further development and evolution (JAMA, 2009). It would, therefore, not seem unreasonable to suggest the medical profession is at a stage in development (evolution) where it would seem sensible to question the basis and validity of current medical conceptualisations and treatments and, where appropriate, re-develop and optimise the world's understanding of illness and application of therapeutic treatments.

In line with the above, this report focuses attention on manic-depressive illness and consideration of the future in respect of its conceptualisation and treatment.

It would seem reasonable to espouse that an illness represents an unnatural state. Therefore, it would seem appropriate to commence assessment in

respect of the validity of the conceptualisation and therapeutic treatment of bipolar disorder, and manic-depressive illness broadly, through analytical consideration with regards to the validity of the notion that it is unnatural to cycle from one extreme to the other, or high to low, as in bipolar.

Examples demonstrating environmental cycling:

- Summer through winter
- Night through day
- Economic peaks and troughs
- Professional athletes cycling between on-season and off-season
- Some artists and musicians have been known to engage in extremely long duration of work (or, creative activity), followed by significant lows
- Hypomanic and manic states have been felt to represent a performance advantage in some individuals that should be leveraged - discussed further below
- The female period (a form of significant cycling with mood changes)

There is evidence to suggest that it is not unnatural for an entity, including persons, to cycle between extremes. There is then argument that the focus be not an attitude that cycling between highs and lows represents an unnatural and inappropriate condition but instead the focus be directed toward ensuring an understanding revolving around the notion that highs and lows are not extreme. However, there is counter argument (that holds merit) that even this may be detrimental and in fact hinder the performance of a person based on factors including: (1) that hypomania (and, possibly mania in certain circumstances) represents a performance advantage in some individuals (Collingwood, 2016; Kiume, 2006); (2) professional athletes in some circumstances cycle between extremes including on-season and off-season training (BBCOM, 2016; RSF, 2016).

There is the argument with regards to whether allowing the person to cycle between extremes poses risk to the community. There is, however, counter argument that in general if the person is acting dangerous toward others then they will be picked up through the law in any event and therapeutic treatment not necessary unless the situation is that the person is requesting it. For instance, if a manic person was out spreading in an automobile then eventually they would likely be picked up through police patrol and speed cameras. If a manic-depressive person was acting violently toward people then they would likely be adequately

hindered through the law given that community members would likely complain.

In extension of the above, there are high risk groups all through society that are dealt with through the law, as espoused for the above. For example, the rate of road accidents for persons aged 18 - 25 years is so much higher and they cause substantially more harm to society than drivers of other age groups (AIHW, 2007; RTA, 2007; TGI, 2015). Another high risk group (though not particularly dealt with by law) is that of obese persons who represent a significant burden on society and arguably themselves.

The fact that hypomania, cyclothymic disorder and other manic-depressive states may in some circumstances represent a performance advantage should certainly be taken into account and it ensured that medical professionals are not hindering a person's performance or quality of life, and controls implemented adequately to ensure there is objective and subjective benefit to any course of treatment offered to patients.

2. Summary and Conclusion

There has been recent research, including that in highly regarded journals such as Journal of American Medical Association (JAMA), which questions the benefit of doctors and the medical profession and whether they may in fact represent a significant cause of harm to patients and that the medical profession needs to continue to strive toward further development and optimisation with respect to the therapeutic treatment of patients. This report focused attention on manic-depressive illness and consideration of the future in respect of its conceptualisation and therapeutic treatment.

The fact that hypomania, cyclothymic disorder and other manic-depressive states (extending to perhaps mania) may in some circumstances represent a performance advantage should certainly be taken into account and it ensured that medical professionals are not hindering a person's performance and quality of life and controls implemented adequately to ensure there is objective and subjective benefit to any course of treatment offered to patients.

In conclusion, the foundations and therapeutic treatment with regards to manic-depressive states should be reconsidered thoroughly, spanning through to the possibility of hypomania (and perhaps mania) not representing illness in certain situations. Therapeutic treatment of any part of the manic-depressive spectrum should be optimised.

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