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Case Report

A Case Study on Bipolar Affective Disorder Current Episode Manic Without Psychotic Symptoms

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Abstract:

Mood disorders are the second most common condition and can repeat for a variety of reasons. Bipolar mood disorders can cause severe manic and depressed episodes that, if not adequately treated, can result in substantial social and personal problems. This study used a single case study approach and was qualitative in nature. A patient with bipolar affective disorder without psychotic symptoms participated in the trial. A case history form and a mental state assessment instrument were used to gather the data, which was then analysed using the content analysis approach. A 27-year-old lady who has been diagnosed with bipolar affective disorder and is now experiencing a manic episode without psychotic symptoms served as the study's sample. The patient was a resident of a private mental health facility in Kerala. This study discovered that pharmacotherapy, family therapy, in-patient rehabilitation, out-patient rehabilitation, and cognitive behavioural therapy can all help manage bipolar affective disorder, current episode manic without psychotic symptoms. The outcome of the current study comprises a thorough analysis of the sample's history and present conditions, along with interventions and management techniques.

Key words: mood disorders; bipolar affective disorder; mania; depression

Introduction

A mood disorder, formerly known as an affective disorder, is an emotional condition that primarily affects our state of mind. A clinically significant disturbance in how a person feels in connection to their surroundings, which results in unhelpful behavior, characterizes a set of mental illnesses known as mood disorders. (Claudio & Andrea, 2022). The primary issue with these diseases is a shift in mood or affect, typically toward melancholy or elation. (ICD-10). Seasonal affective disorder (SAD), major depressive disorder (MDD), and bipolar disorder (BD) are a few examples of mood disorders. These conditions can also be further classified according to the severity, timing, or suspected cause of the illness. (APA, 2013). Patients with mood disorders have bodily and cognitive abnormalities that impair their ability to function. One such change is the disruption of the sleep–wake cycle, which shows up both physiologically and behaviourally. (Claudio & Andrea, 2022).

Mood disorder patients exhibit two key moods: mania and depression. The extreme sorrow and hopelessness that characterize depression (Hooley et al., 2016). People during depressive episodes will have a persistent depressed mood and may lose interest in previously pleasurable activities along with significant changes in sleep pattern and appetite for at least two weeks. According to the diagnostic criteria of DSM-5, symptoms of a depressive episode include depressed mood, significant changes in sleep patterns and appetite, psychomotor agitation or retardation, diminished ability to think and concentrate, and recurrent thoughts of death. 60% to 90% of major depressive disorder patients experience sleep difficulties, with insomnia and hypersomnia being the most prevalent disorders. This varies depending on how severe the depression is. (Abad & Guilleminault, 2005).

Mania is the other major mood. The extreme and irrational enthusiasm and exhilaration that characterizes mania. When experiencing a manic episode, a person's mood is noticeably heightened and expansive, perhaps being interrupted by intensely irritable outbursts. (Hooley et al., 2016). For a precise diagnosis, these significant mood swings must last for at least a week. The existence of an abnormally high, expansive, and irritable mood for at least four weeks is the hallmark of the milder variant known as a hypomanic episode. Considering its difficult clinical presentations and long-term view, a patient with mania must be provided with a personalized treatment for functional recovery. Psychoeducational strategies are also used for the maintenance of treatment results (Pacchiarotti et al., 2020).

There are two main classifications of mood disorders. Both unipolar and bipolar mood disorders exist. Unipolar mood disorders are characterized by the recurrent occurrence of full-blown depressive episodes. For a clear diagnosis, the person must show the symptoms of a depressive episode for longer than two weeks. If a person suffers from the occurrence of depressive episodes for about two years, then the person can be diagnosed as having persistent depressive disorder (PDD) or formerly known dysthymia. Here the symptoms are commonly found as half-blown (Hooley et al., 2016).

Bipolar mood disorders are characterized by the presence of both key moods, that is, Depression and mania. A person with bipolar disorder may alternatively experience both depressive and manic episodes (Hooley et al., 2016). Bipolar I disorder and bipolar II disorder are subtypes of bipolar disorders. Among these, the occurrence of mixed episodes—which are characterized by symptoms of both full-blown manic and severe depressive episodes lasting at least one week—signals the existence of bipolar I disorder. When a person has significant depressive periods and hypomanic episodes, bipolar II disorder is identified. When a full-blown manic episode is lacking in a patient with bipolar II disorder, this condition is known as cyclothymia. When someone exhibits half-blown bipolar mood disorder symptoms for at least two years, it is diagnosed. (World Health Organization, 1992).

Suicide and mood problems are related. Compared to the non-clinical population, the clinical group has a much greater prevalence of suicidal conduct. (Shah et al., 2022). Mood disorders can occur with or without psychotic symptoms and they can be seen as associated with somatic symptoms (World Health Organization, 1992). It was shown that kids with social anxiety disorder were more likely to also have a mood problem. It was discovered that those kids had more significant anxiety issues prior to therapy. Recent research says that the treatment of mood disorders was related to anxiety reduction (Baartmans et al., 2022).

Causal factors of mood disorders focus on biological, psychological, and socio-cultural factors. Family studies and twin studies have indicated that the prevalence of mood disorders is around two to three times greater among blood relatives due to biological variables. (Akdemir&Gokler, 2008). This shows the genetic influence in increasing the vulnerability towards the development of unipolar mood disorders. Neurochemical factors and hormonal regulatory and immune system abnormalities can also contribute to mood disorder development. psychological root causes Consider stressful life situations as key causative variables. Numerous studies have demonstrated that extremely stressful life situations might serve as precursors for mood disorders. Numerous studies have shown that this illness has an impact on patients' whole families and may reduce their fortitude and adaptability.

Treatment and management of mood disorders include pharmacotherapy, psychotherapy, and alternative biological treatments. Pharmacological methods cannot be avoided in the treatment of mood disorders. Anti-depressants, anti-psychotics, and mood-stabilizing drugs are found to be commonly used in treating mood disorders. Monoamine oxidase inhibitors (MAOs) and selective serotonin reuptake inhibitors are examples of antidepressants (SSRIs). Patients with mood disorders are treated with lithium as a mood stabilizer. Several forms of psychotherapy are used widely for treating mood disturbances [Datta et al., 2021].

It is common to employ therapies including behavior activation therapy, family and marital therapy, interpersonal therapy, and cognitive behavioral therapy (CBT). In addition to these pharmacological methods and psychotherapies, several biological approaches include electroconvulsive therapy (ECT), bright light therapy, and deep brain stimulation.

When a person has bipolar affective disorder, the present episode is manic without psychotic symptoms (ICD F30.1) and they have previously experienced at least one prior affective episode (hypomanic, manic, depressed, or mixed). (ICD 10) Mania is defined by an elevated mood that is discordant with the patient's condition and lacks psychotic symptoms. It can range from thoughtless merriment to practically uncontrollable excitement. Increased energy that comes with elation causes overactivity, pressure in speaking, and a reduced desire for sleep. There is a lack of continuous attention, and distractions are frequently obvious. Overconfidence and lofty ideals can inflate one's sense of self-worth. Loss of typical social inhibitions can lead to actions that are careless, foolish, or out of character for the situation. (ICD 10).

Relevance Of the Study:

Mood disorders are the second most prevalent type of disorder in psychopathology. Mood disorders are commonly seen with relapses and recurrences. So, a continuation of medication and follow-up sessions are necessary. However, at least half of the people are never receiving adequate treatment. So, this particular study can help in reducing stigma and human rights violations towards the affected people. And, through this particular study, people can have more awareness about mood disorders, Specifically the bipolar affective disorder, current episode manic without psychotic symptoms.

Review Of Literature:

Shah, K., Trivedi, C., Kamrai, D., Srinivas, S., & Mansuri, Z. (2022) conducted a study on suicide in adolescents with mood disorders. The study's goals were to examine the relationship between youth suicide and mood disorders as well as the influence of comorbid conditions in disruptive mood dysregulation disorder on adolescent suicidal thoughts. The National Inpatient Sample dataset was utilized in the study to select individuals with mood disorders, and the Chi-square test was employed to compare groups. According to the study, teenagers with mood disorders

who do not have disruptive mood dysregulation disorder had approximately double the chance of having suicidal thoughts or actually attempting suicide.

Baartmans, J. M. D., van Steensel, F. J. A., Klein, A. M., & Bögels, S. M. (2022) conducted a study on The Role of Comorbid Mood Disorders in Cognitive Behavioral Therapy for Childhood Social Anxiety. The study aimed to determine the degree of occurrence of mood disorders as the result of cognitive behavioral therapies in children with social anxiety. The sample of the study consisted of 152 children who were clinically diagnosed as having social anxiety or any other anxiety disorder. The findings imply that children with social anxiety are more likely than those with other anxiety disorders to also have comorbidity with a mood condition.

Rashid, M. H., Ahmed, A. U., & Khan, M. Z. R. (2019) conducted a study on substance abuse among bipolar mood disorder patients. Determine the prevalence of drug use among patients with bipolar mood disorder was the goal of this descriptive cross-sectional investigation. 115 bipolar patients made up the sample; both males and females, inpatients and outpatients, were taken into account. Data collection was done using a standardized questionnaire. According to the survey, 23.8% of the respondents engaged in drug misuse.

Deepika, K. (2019). conducted a study on a case report on bipolar affective disorder: Mania with psychotic symptoms. The study adopted the method of a case study which aims to find the key characteristics and implications of mania with psychotic symptoms.

Akdemir, D., & Gokler, B. (2017) conducted a study on psychopathology in the children of parents with a bipolar mood disorder. The purpose of the study was to determine how frequently offspring of parents with bipolar mood disorder experience mental illnesses. 33 children of 28 control parents and 36 children of 28 parents with bipolar I illness made up the sample. The SADS-L (Schedule for Affective Disorders and Schizophrenia-Lifetime Version) and the SADS-L for School-Aged Children (Present and Lifetime Version) are screening tools (K-SADS-L). According to the study, children of parents with bipolar illness had a greater prevalence of psychopathology than children of the control group.

Method And Research Design:

A case study can be defined as a record of research that consists of information about the development of a particular individual, group, or situation over time. It is a systematic investigation of a single individual or group of individuals which uses several statistical and psychological tools (McCombes, 2022)

The present study adopted the case study method. It is consisted with combined form of exploratory, cumulative and critical instance case studies. As a case study is an in-depth investigation of a person, a group of individuals, or a unit with the intention of generalizing it on several occasions. it allows us to explore the characteristics, meanings, and implications of the particular case. Exploratory case study involves detailed research of the subject aimed at providing an in-depth understanding of the study. Cumulative case study involves generalizing a phenomenon after collecting information from different sources. Critical instance case study aims in determining the cause and consequences of an event.

In this case study, case history and mental status examination have been taken from the client and informants. Information collected was cross-checked and reversed twice, and reliability and adequacy were also assured.

Sample Description:

A 27-year-old female inpatient with the bipolar affective disorder, current episode manic without psychotic symptoms. The patient was a married woman from a middle-class family who has been taking treatment for the past 10 years. The case was taken from one of the private mental health establishments in Kerala to which the patient was admitted. The patient was admitted to the hospital for 20 days, from there the data were collected by the researcher.

Tools:

The present study uses Mental Status Examination (MSE) and case history. An MSE is an inevitable part of the clinical assessment which helps find the current state of the client, under the domains of general appearance, mood, affect, speech, thought process, perception, cognition, insight, and judgment.

A case history includes an in-depth analysis of a person or group. It mainly has detailed information relating to the patient's psychological and medical conditions. A case history is used to get a client's test results, and professional, sociological, occupational, and educational data. The data collected in a case history includes socio-demographic data, presenting complaints and their duration, nature of the illness, history of present illness, negative history, treatment history, family history, personal history, and pre-morbid personality.

Data Analysis:

The Present study uses the tool content analysis for analyzing data. Content analysis is a research tool that helps analyze the presence, meaning, and relationship of certain words or concepts. Content analysis is also helpful in quantifying the collected information.

Ethical Concerns:

Full consent from the participant was obtained. The confidentiality of the data collected from the participant was ensured. The participant is not harmed in any way. The anonymity of individuals and the privacy of the participant is ensured.

Result And Discussion:

Case History:

Socio-demographic data: The patient named J.O.V., is a 27-year-old female, hailing from a middle-class family who has been educated up to plus two and is presently unemployed. She was a married woman and mother of a 2-year-old child. The informants were the patient, her husband, and her sibling. The collected information was adequate and reliable.

Presenting complaints and their duration: Reported by the patient- The patient has reported that she was suffering from a decreased need for sleep and tended to throw objects when got angry, for the last seven months. For the past four months, she an increased craving for food and a feeling that people are avoiding her complained and also complains that her family is cursing that she is not attending to her child properly.

Reported by the informant: The informant has complained of lack of sleep (not sleeping for about 48 hours), not giving proper attention to the child, suicidal tendency, increased talk, getting raised easily, and throwing objects when got raised for the past seven months. They also complained about spending a lot of money on buying mobile phones, ornaments, and gadgets, and, overuse of mobile phones for the past four months.

Nature of illness: The onset of illness was found to be gradual. The course was episodic and stable progress has been identified. Precipitating factors were not elicited.

History of present illness: The patient was maintaining normal till seven months back. Then she started getting raised quickly without any reason and experienced a decreased need for sleep. She felt that everyone around her is trying to avoid her. When having such feelings, she preferred to be alone and isolated herself. At times she lost her interest in everything, so she will not do anything and simply sit alone without doing anything. After that, the patient started spending a lot of money buying ornaments, mobile phones, and gadgets. She experienced an increased craving for food. She had the wish to eat all time a day. Before four months her mood suddenly changed to an extraordinary sadness and continued lack of sleep. Then she started to elicit highly irritable behavior with increased talk. Her symptoms caused impairments in her personal and social life, as she became more irritable with decreased sleep and a situation of missing from the house. As she began not to attend even her child properly, her family brought the patient to one of the private hospitals in Kerala for treatment and getting In-patient care.

Negative history: The patient has no history of head injury, trauma, epilepsy, headache, and vomiting. There is no history of psychoactive substance use. The patient shows no history of seeing or hearing things that others cannot see or hear. There is no history of the patient having repeated ideas, thoughts, or images coming to her mind. The patient has no history of irrational fear towards objects, events, or situations.

Treatment history: The patient had taken treatment with in-patient care previously from another private hospital in Kerala. Then she took treatment from one of the Government medical colleges, Kerala In-Patient care for 20 days. In 2017, treatment was taken from another private hospital, in Kerala for 20 days. Then she took treatment from another Government medical college, several times.

History: When the patient was 17 years old, the family identified behavioral changes such as increased talk, decreased need for sleep, and irritability. The patient was complaining that these changes occurred as a result of losing her friendship and love. But the family is not giving assurance for her complaint. Then she was taken to a private mental health centre, in Kerala for treatment and In-Patient care. There found an improvement with the treatment. She got married at the age of 21 years. After marriage, she started to show her symptoms including irritable behavior and increased talk. Due to this, the relationship got divorced 3 months after the marriage. After the divorce, she attempted suicide by jumping into a well. So, she was taken to one among the Government medical college hospital in Kerala, and was admitted for about 20 days (2015). The patient showed improvement with the treatment. Approximately 1 year later her symptoms started to reappear, and she went to another hospital alone for gaining treatment (according to the client). But the family brought her back and took treatment at a private mental health centre as in-patient for 20 days (2017). She showed improvement with the treatment. After that the client showed similar symptoms and has been getting medical care as in-patient several times from Government medical college, Kerala. 4 years later, she got married again. The relationship happily continued and she gave birth to a child. 7 months back she got hit by the current episode.

Family history: Consanguinity is absent. The patient belongs to a middle-class family, where her husband and brother are the earning members. The patient's father is the family decision-maker. The patient maintained a good relationship with the family. General interaction within the family is good. There is a history of the psychiatric problem in her family. There found a history of wandering and missing out(grandfather). In the mother's family, there is a history of suicide(grandfather) and mental illness(grandmother). The information about the illness is not known adequately. Her mother shows a history of bipolar affective disorder and her elder sister has a history of suicidal attempts and thyroid. There is no history of substance abuse in the family. The family is aware of the patient's illness. Several members of the patient's family show mental and behavioral dysfunctions and there are interpersonal conflicts in the family. So, family dynamics are dysfunctional.

Personal history: The birth and development of the patient were appropriate. There are no complications during delivery. The delivery was full-term and normal at the hospital. There are no significant abnormalities in the pre-natal and post-natal development. The development milestones were age appropriate. The patient was brought up by their mother. There is no maternal deprivation observed. There is no history of neurotic traits such as nail biting, body rocking, night terrors, phobias, and stammering. Education history started education at 5 years. She belongs to an average student. The medium was Malayalam. She had many friends but the relationships were not well maintained. She discontinued her degree (BA Literature) during her first year due to illness. Relationships with teachers were not good. Occupation history: The patient started an occupational career at the age of 25. She worked as a sales girl in a gold shop for about 2 months and left the job due to the pandemic situation.

Marital history: The patient got married at 21. The marriage was an arranged one with the consent of the family but got divorced after a relationship of only 3 months. Her disorder was the primary reason for the divorce. After 4 years, when she was 25 years old, she married again. The marriage was also an arranged one with the consent of the family. The husband is supportive. Currently, the client and her husband are satisfied with the relationship. Sexual history: the mode of gaining sexual knowledge is from friends. No history of sexual abuse is found. Marital sexual life is also satisfied. Menstrual history: menstrual cycle(menarche) begins at the age of 14 years. There are no significant abnormalities in the response to menarche noted. Then after the menstruation is regular till now. There were no mood swings during the menstrual cycle, but the client complained about back pain during menstruation. Substance use history, the patient has no history of any psychoactive substance use.

Pre-morbid personality: Attitude towards self, she was a confident personality but was not able to make decisions. And she maintains an average level of self-esteem. Attitude towards others: she was an extrovert who quickly feels empathetic towards others. She doesn't have many intimate friends. She always kept a good relationship with her family. She was not much talkative in the family except with her mother. The predominant mood was happy. Moral standards, she is a religious person who keeps religious rituals always. Stress reaction, she was able to tolerate and deal effectively with stress. Habit, the sleep pattern was normal, and had no habit of doing exercises. Fantasy life, dream with the content of 'falling into the water. Other personality traits, there is no presence of personality traits such as OCD, ADHD, ODD, emotionally unstable personality, impulsivity, and narcissistic personality

Mental status examination (MSE)

General appearance and behavior: The patient was alert, attentive, and conscious during the session. The patient's dressing was appropriate. Eye contact was established and maintained. A good rapport was made. The patient's attitude toward the examiner was cooperative. Reality contact was present. Tics/mannerisms and catatonic phenomena were absent.

Psychomotor activity: Increased psychomotor activity by walking during the session and drinking a lot of water.

Speech: The speech was relevant and coherent. Reaction time was normal. Volume and tone were normal and she maintained the prosody of speech.

Mood and affect: The mood were sad and her affect was shallow which was inappropriate to the situation and congruent to the thought content.

Thought: The patient doesn't show any abnormalities in the stream, form, possession, and content of thought. That is., there is no presence of flight of ideas, circumstantiality, tangentiality, obsessions, compulsions, etc.

Perception: There is no presence of hallucinations and illusions. Other psychotic phenomena such as somatic passivity and made phenomena are absent. Other phenomena like depersonalization and derealization are also found to be absent.

Cognitive functions: Attention and concentration, the digit span test, and serial subtraction were given. In forward, the digit span is 4 and in backward the digit span is 3. In the serial subtraction test, the patient completed the task in 115 seconds. This shows that the patient's attention was aroused and maintained. Orientation, the client was asked questions of time, place, and person, and found that the patient's orientations were intact. Memory, the patient's immediate memory was tested by conducting a recall test. The patient was able to recall what the examiner has said. The recent memory of the patient was tested by asking her questions regarding the past 24 hours and it is found that the patient's recent memory was intact. Remote memory was tested by asking questions about personal details such as to say her date of birth. From this, it can be concluded that the patient's memory was intact.

Intelligence: General information, the patient was asked questions for testing general knowledge. The responses of the patient indicate that general information is adequate. Comprehension, the patient's comprehension is assessed by asking some situational questions and is found adequate. Arithmetic ability, after comprehension, the arithmetic ability of the patient is assessed by asking some simple arithmetic questions and is found adequate. Abstract ability, the patient's abstract ability is assessed by giving tests to find similarities and dissimilarities of objects the examiner is saying. Proverbs are given to the patient and asked to explain them. The assessments of general information, comprehension, arithmetic ability, and abstract ability indicate that the patient has an average intellectual capacity.

Judgment: The patient's personal, social, and test judgment is found to be intact.

Insight: The patient has a level five insight. Since she is accepting all her minor and major symptoms and is also aware of the need for treatment.

Provisional diagnosis: F31.1 (ICD-10 CLASSIFICATION) Bipolar affective disorder, current episode manic without psychotic symptoms.

Diagnostic guidelines: For a definite diagnosis

a) The present episode has to meet the requirements for mania without psychotic symptoms. and
b) There must have been at least one prior affective episode in the past, whether it was mixed, hypomanic, manic, or depressed.

Diagnostic criteria for mania: The episode must last at least a week and be severe enough to substantially interfere with daily tasks and social interactions. Energy levels should rise along with a few of the symptoms listed below when the mood changes.

a) Decreased need for sleep
b) Grandiosity
c) Excessive optimism
d) Particularly pressure of speech

The patient has had such emotional episodes in the past and has recently had greater energy, decreased sleepiness, and excessive optimism. Given that this fits the aforementioned requirements, we can provisory classify the patient's present manic episode as having bipolar affective disorder.

Interventions And Management Plan:

A medical doctor or trained clinical psychologist determines an intervention and management plan for any mental disturbance. Since Bipolar affective disorder is a long-term condition, continuous and prolonged treatment is needed. Professionals suggest several management strategies for bipolar affective disorder treatment. This often includes:

Hospitalization- Doctors often prefer hospitalization if the patient seems to be more dangerous and has suicidal ideas. Psychiatric hospital care helps stabilize the patient's mood, and, maintains a safe and calm atmosphere.

Medications- Several medications are used in treating bipolar disorders. Taking medication helps balance your moods in the right way. The types and doses of medicines are determined by the doctor. Commonly prescribed medications in the treatment of bipolar affective disorder include:

i. Mood stabilizers- This includes lithium, valproic acid, equator, etc.
ii. Antipsychotics- Olanzapine, risperidone, aripiprazole. This comprises commonly prescribed antipsychotics.
iii. Antidepressants- Antidepressants are given to manage depression. But these are prescribed along with mood stabilizers or antipsychotics since antidepressants trigger mania.
iv. Anti-anxiety medications- This has benzodiazepine in it. This provides better sleep and also helps with dealing with anxiety.

Psychotherapy- bipolar disorder treatment includes psychotherapy on a regular basis. Numerous therapies may be beneficial. A family, a group, or an individual may get therapy.

Treatments provided include:

i. Cognitive Behaviour Therapy (CBT)- The goal of this treatment is to discover unhealthy ideas and behaviors and replace them with constructive ones.
ii. Psychoeducation- Learning about bipolar illness can help patients better comprehend their current situation, prevent relapses, and adhere to therapy.
iii. Family-focused therapy- Family therapy helps make the family of the patient aware of the disorder and warning signs of bipolar episodes.

If the patient doesn't improve with antidepressants, further therapeutic options include electroconvulsive therapy (ECT) and occasionally transcranial magnetic stimulation.

Conclusion:

This study discusses a case of bipolar affective disorder, current episode manic without psychotic symptoms. Here the study concentrates on the characteristics, symptoms and features of bipolar affective disorder, current episode manic without psychotic symptoms and also the interventions used for this case. For those who suffer from bipolar affective disorder, the present episode is manic without psychotic symptoms, and the patient has previously had at least one prior affective episode (hypomanic, manic, depressed, or mixed). (ICD 10) Mania is defined by an elevated mood that is out of proportion to the patient's circumstances and can vary from casual merriment to almost uncontrollable excitement. Mania is characterized by the absence of psychotic symptoms. Overactivity, difficulty speaking, and a diminished need for sleep are all symptoms of the increased energy that comes with joy. Continuous concentration is lacking, and distractions are usually evident. An exaggerated feeling of self-worth can result from overconfidence and ambitious ambitions. Losing one's normal social inhibitions might cause one to act carelessly, foolishly, or inappropriately given the circumstances.

Limitations:

The study adopted a single case study method, the result cannot be generalized to larger populations.

Declarations:

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Conflicts of interest/Competing interests

The authors have no financial or non-financial interests to report.

Data Availability Statement

Only datasets produced during and/or analyzed during the current investigation are available upon reasonable request from the corresponding author.

Authors' contributions

the two writers have each made a meaningful contribution and agree that they should both be given authorship credit.

Ethics approval

The Departmental Research Committee granted ethical approval.

Consent to participate

Informed consent was taken from the informant and also from the institution

Consent for publication

All authors of this research Study consent to the work being used for publication.

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The article, A case study on bipolar affective disorder, current episode without psychotic symptoms (ICD F 31.1), is a record of original research effort, we therefore declare. We attest to the work's originality and the absence of any instances of plagiarism across the whole manuscript.

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