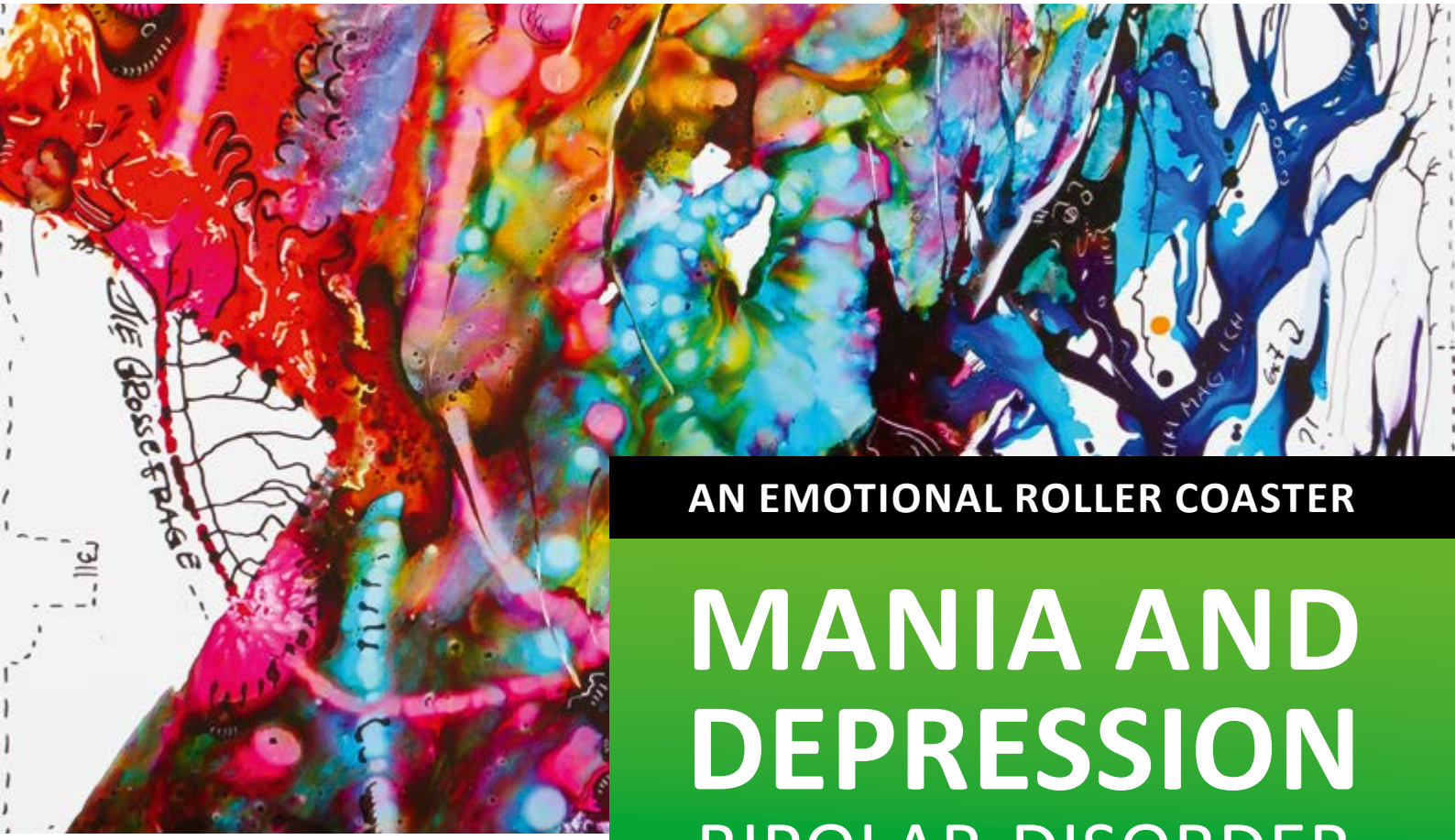
DGBS
Deutsche Gesellschaft für
Bipolare Störungen e.V.



AN EMOTIONAL ROLLER COASTER

MANIA AND DEPRESSION

BIPOLAR DISORDER

A guidebook for sufferers and their family members

Rita Bauer, Michael Bauer, Ulrike Schäfer, Volker Mehlfeld, Martin Kolbe

THE CREATIVE SIDE OF BIPOLAR DISORDER

All the works shown in this booklet are by bipolar artists. Information on the creators of the works used can be found on page 58.

We would like to thank all the artists for allowing us to use their work!

DGBS GUIDEBOOK 3RD EDITION 2017

AUTHORS **Rita Bauer, Michael Bauer, Ulrike Schäfer, Volker Mehlfeld, Martin Kolbe**

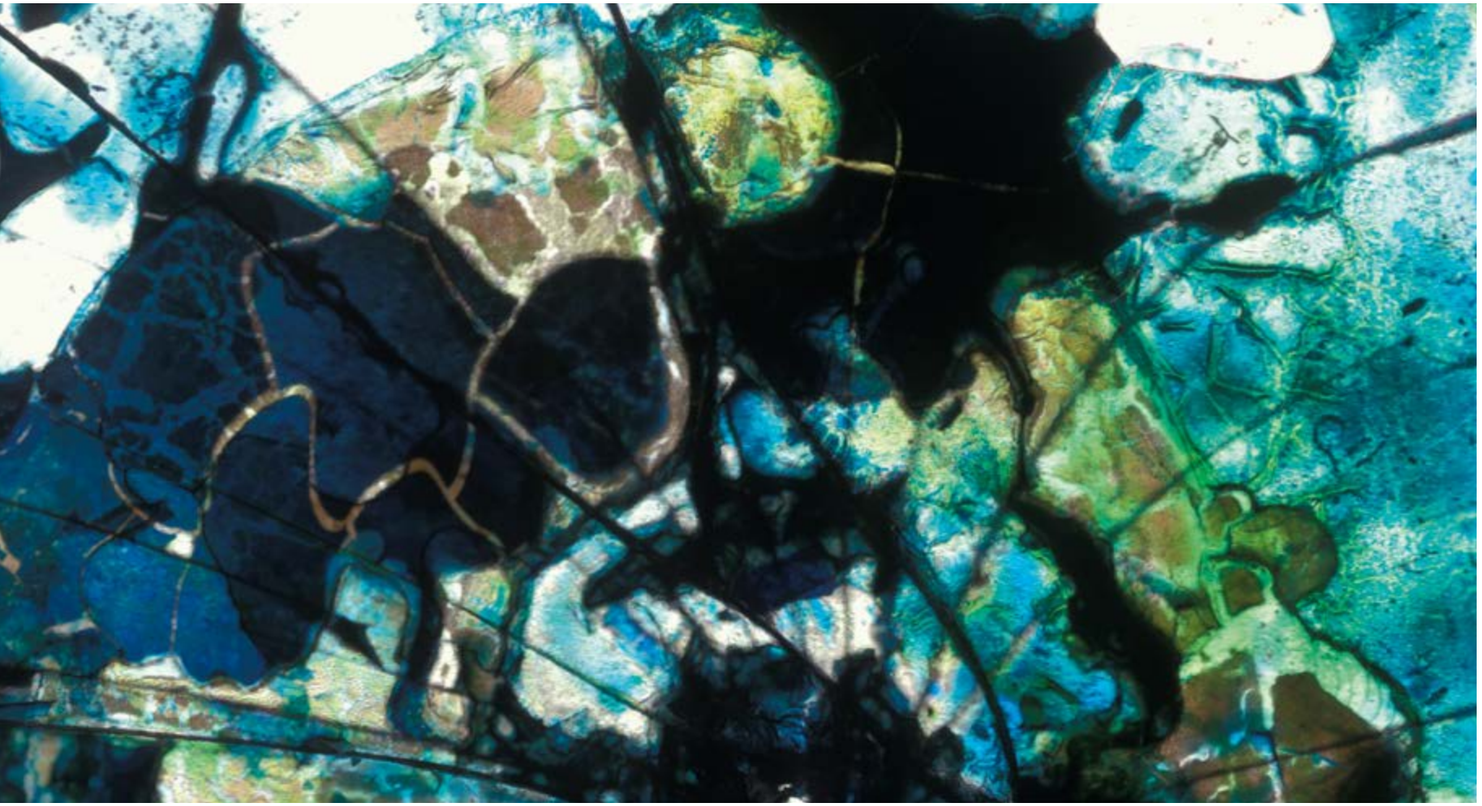
PUBLISHER **Deutsche Gesellschaft für Bipolare Störungen e.V.**

Adress DGBS · Psychiatric Clinic ı Heinrich-Hoffmann-Str. 10 · 60528 Frankfurt/M
Telephone +49 (0)69 630 184 398
Email info@dgbs.de
Website www.dgbs.de

DGBS Chair Prof. Dr. med. Martin Schäfer, Essen
Register of Associations Freiburg im Breisgau District Court Registration number VR 3310

Layout & typesetting: Selina Peterson ı www.selina-peterson.de

CONTENTS



PREFACE

Bipolar affective disorder (previously known as manic depression and abbreviated in this guidebook to bipolar illness or bipolar disorder) manifests as episodes (phases) and can substantially interfere with quality of life, in particular as regards psychosocial development, making early detection and treatment extremely important. The condition often develops in early adulthood, i.e. during a formative phase for plans that will affect someone's future life (e.g. education). It is an illness that has a negative impact not only on the sufferer but also their whole family.

It is important to recognise the first signs of a phase in order to be able to take appropriate counter-measures. The key treatment strategies are medication on the one hand and psychotherapy on the other.

The better informed the sufferer and his/her family members are about the progression of the illness, the more effective the management of the illness will be. The aim of this guidebook is to help people recognise the symptoms of the illness in good time and to explain the key treatment strategies. In addition to medication in the acute phase of the illness, preventative (prophylactic) medication is also given to prevent further relapses. A prerequisite for this, however, is that patients and their family members are prepared to cooperate fully with their doctors. This short guidebook is intended to provide introductory information. It cannot, of course, replace discussion with your doctor.

The Deutsche Gesellschaft für Bipolare Störungen e.V. (German Society for Bipolar Disorders) (DGBS; www.dgbs.de) was created with the aim of enabling professionals, sufferers, family members and everyone involved with healthcare to share their knowledge. The objective of the DGBS include raising awareness of the needs of people with bipolar disorder amongst the public and policy makers and promoting self-help, further training and research. We are always grateful to receive any suggestions or comments.

The authors, autumn 2017

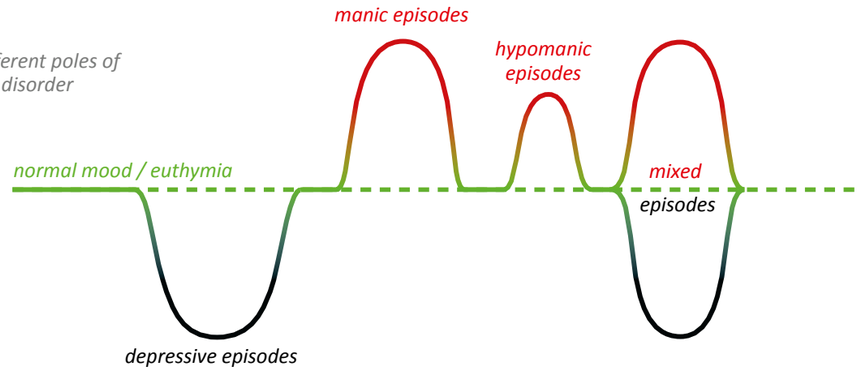
WHAT IS BIPOLAR DISORDER?

Bipolar disorder involves episodes, and sometimes a great many of them, where mood and activity level are significantly disturbed. These can manifest as elevated mood, heightened energy and increased activity (mania), or depressed mood, diminished energy and decreased activity (depression).

So sufferers may experience two opposing moods: on the one hand, euphoric and “on top of the world”, and on the other, a depressive, despondent mood, “sunk in despair”. They experience an emotional roller coaster.

The mood swings can be so strong that they make it impossible to live a normal, everyday life. Milder, less pronounced disturbances are also possible in addition to these extremes of mood and the associated changes in behaviour and thinking. Some sufferers also experience phases in which manic and depressive symptoms appear at the same time (known as mixed episodes).

The different poles of bipolar disorder

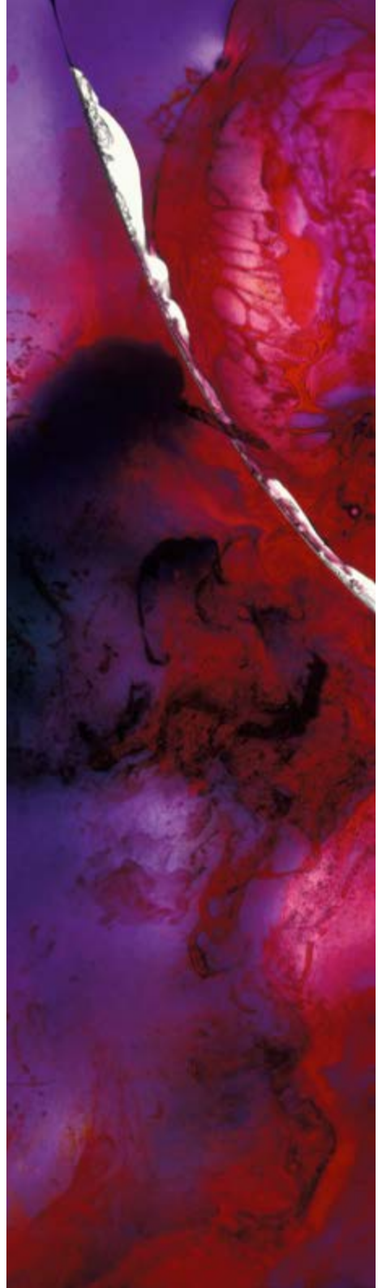


POSSIBLE CAUSES AND CONDITIONS FOR DEVELOPMENT

It is generally assumed that a number of different factors interact closely with each other to make someone more likely to develop the condition. **The key issues here are hereditary (genetic) factors on the one hand and psychosocial stress on the other. It can also be assumed that biological and psychosocial factors are interlinked.**

Bipolar disorder has a strong genetic component. Susceptibility, i.e. the likelihood of developing the illness, is inherited. However, manic depressive illness is not a hereditary illness in the strict sense of a defective gene being responsible for the illness. Genetic factors nonetheless play a significant role: it is assumed today that a large number of genes (probably more than 100 - research in this area is continually developing) play a role in the development of the condition. About 50% of all those with bipolar disorders have family members who also suffer from the condition. For monozygotic twins (i.e. twins who are genetically identical) the probability of one twin suffering from a bipolar disorder if the other is bipolar is between 60% and 80%. For dizygotic (fraternal) twins, the probability of developing the illness is 20%. Family research and studies of twins and adoption have demonstrated that the risk of developing the illness is increased for first-degree family members (i.e. for example the children of bipolar parents). First-degree family members not only have an increased risk of developing bipolar disorder but also an increased risk of developing unipolar depression or other mental illnesses such as anxiety disorders or alcohol and/or drug abuse.

Bipolar illness is also not a “classic” hereditary illness, that is, you cannot say for certain that the child of a bipolar person is highly likely to develop the illness. Other factors, in particular environmental factors, must always be taken into account. How someone’s environment and genetics interact is still largely unknown at present. To date it has been assumed that it is not one single gene but the interplay of a certain genetic pattern that is responsible for genetic susceptibility to bipolar disorder. It is assumed in particular that these involve changes in the genes associated with the metabolism of neurotransmitters. Neurotransmitters are chemical messengers that help transmit nerve impulses in the brain. Changes in neurotransmitters are observed in people suffering from bipolar disorder during the various phases of the illness. Neurotransmitters are used for communication between cells. The neurotransmitters noradrenaline and serotonin are particularly involved with depression whereas during manic phases there are likely to be increased levels of dopamine and noradrenaline.



Bipolar illness may also involve biological impairment of the calcium ion channels through which cells exchange calcium, thus impeding the transmission of certain information. Neuroendocrinological findings indicate the presence of other biological factors, hypothesising imbalances in the hormone-regulating regions of the brain (hypothalamus and pituitary), the renal cortex and the thyroid. It has thus been possible, for example, to demonstrate increased concentrations of cortisol in patients experiencing mania and patients experiencing mixed episodes of bipolar disorder.

In addition to the biological factors, triggers play a critical role. Stress should be mentioned here as a particularly important trigger for bipolar disorder. Stressful life events or situations that are experienced as seriously stressful , for example separation, divorce, or the death of a close relative can be triggers for bipolar illness, but so can significant life changes that are not fundamentally negative, such as marriage, moving home or retirement. Episodes can also occur after stressful periods, for instance after passing an examination. It is often the case that there has been a high stress load before the initial episode of the illness whereas later phases are less associated with prior stress (this is known as the kindling effect). Disturbance of the sleep/wake cycle, especially sleep deprivation, can trigger episodes. Episodes can also be triggered by other psychosocial stress factors, drug usage and/or excessive alcohol consumption.

In summary, it can be assumed that there is no one single cause that gives rise to bipolar illness; it is the result of the interaction of a range of biological (in this case mostly genetic) and environmental factors, especially stress. The so-called “stress vulnerability model” is relevant: this is the interaction of genetic susceptibilities in the development of bipolar disorder. But in the context of such pre-existing vulnerability (susceptibility of the brain to particular stressors), the illness only manifests when unfavourable life situations arise. An understanding of the “stress vulnerability model” can help sufferers to exert greater influence over their illness by trying to recognise and minimise individual stress factors.

PROGRESSION OF BIPOLAR DISORDER & DIFFERENT FORMS OF PROGRESSION

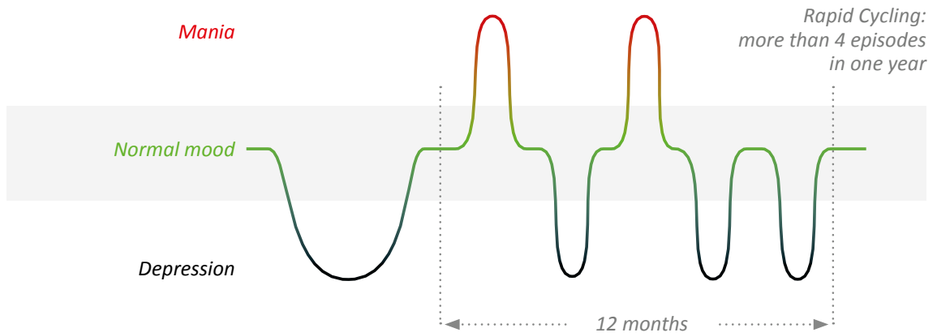
Bipolar illness is characterised by so-called episodes that take the form of mania, depression, hypomania (slight mania) or mixed manic-depressive states. This changeability is typical of affective disorders, of which bipolar illness is one example. Between individual episodes, healthy, “illness-free” intervals can occur where patients are completely symptom-free. The symptom-free periods often become shorter with increasing age and phases of illness can become increasingly frequent: preventative medication is used to avert these.

Bipolar illness usually appears for the first time in adolescence or early adulthood. This is highly significant because the illness manifests at a time when the individual still has many important developmental steps ahead of them, such as finishing school and undertaking training. However, the illness often goes unrecognised in adolescence; mood swings are misinterpreted as the unpredictability of puberty. Changes are often only correctly classified in retrospect in the context of later phases of the illness. When a depressive episode first occurs, it cannot immediately be classified as bipolar illness; this can only happen when subsequent manic or hypomanic episodes have also occurred. This is the point at which bipolar illness can be diagnosed.

Follow-up studies have shown an increased risk of relapse (recurrence) where there were severe depressive episodes in childhood and adolescence. Investigations have shown that progression is less likely to be favourable the younger the age of onset, the more frequently episodes occur (e.g. several times a year), if episodes are frequent and extreme, (and have psychotic attributes), if individual episodes are prolonged, if the illness abates only partially, if other serious physical or mental illnesses are present (e.g. addiction or anxiety disorders), or if there are suicidal thoughts or suicide attempts.

A number of progression categories can be identified:
Bipolar group I who experience manic and depressive episodes and **bipolar group II** who experience solely depressive and hypermanic episodes (that is to say, no mania).

“Rapid Cycling” is a special form of bipolar disorder and denotes progressions that involve rapid swings between phases or at least 4 phases of depression or mania in the previous year Another form of the condition are so-called “mixed” episodes where both depressive and manic or hypomanic symptoms appear at the same time. These symptoms can change from day to day and from hour to hour.



It is also possible to distinguish various phases of treatment. First, there is the acute phase (with either depressive or manic or mixed symptoms) and the remission phase i.e. regression of symptoms. Depressive episodes last about 3 to 6 months without treatment, and mania about 2 to 4 months (on average! these can differ significantly from case to case). This is followed by the relapse prevention or long-term therapy phase, which aims to prevent further episodes.

In summary, bipolar illness is characterised by repeated phases of depression or mania. Without treatment, increasing numbers of depressive or manic phases can arise over time. Timely treatment on the one hand attempts to alleviate acute symptoms and on the other hand aspires to prevent or at least mitigate recurring episodes.

SYMPTOMS OF BIPOLAR DISORDER

DEPRESSIVE EPISODES

The main symptoms of depression are despondency accompanied by fear, sadness, worry, despair, joylessness, unhappiness, feelings of emptiness and numbness, inability to take pleasure in anything and hopelessness. These are accompanied by a reduction in self-confidence with feelings of inferiority, self-deprecation, feelings of guilt and failure. There is also a reduction in energy and activity with lack of interest, passivity, indecisiveness, slower movements and inner disquiet.

Symptoms also include impaired reasoning and speech with slower, inhibited or impeded ability to think, lack of ideas, brooding, disrupted concentration and alertness, memory problems with impaired retention capacity, quiet, slow speech, reduction in speaking, repetition of the same depressive thoughts and also (especially in older patients) increased despondent moaning. Physical symptoms in the context of depression can be highly diverse: feelings of tiredness and exhaustion, powerlessness, increased need for rest, loss of libido, difficulty falling asleep and staying asleep, early waking or increased need for sleep. Loss of appetite and associated weight loss and increased appetite with weight gain can both occur. Depressed people can also behave in a withdrawn manner, no longer wanting to socialise or go out, and avoiding company.

CLASSIFICATION UNDER ICD-10
(International classification of psychiatric disorders, World Health Organisation)

a) mild (F32.0): at least 2 main and 2 additional symptoms

b) moderate (F32.1): at least 2 main and 3-4 additional symptoms

c) severe; with/without psychotic symptoms (F32.2 / F32.3): all three main and at least 4 additional symptoms, some of which are severe

Minimum episode duration: approx. 2 weeks

MAIN SYMPTOMS:
- Depressive mood
- Loss of interest, joylessness
- Lack of energy, increased fatigue

ADDITIONAL SYMPTOMS:
- reduced concentration and alertness
- reduced self-worth and self confidence
- feelings of guilt/worthlessness
- negative, pessimistic view of the future
- suicidal thoughts and behaviours
- sleep disturbances
- reduced appetite

Principal symptoms of depression

- low mood
- reduced energy
- inner disquiet
- loss of joy or interest
- increased fatigue
- decreased self-esteem
- self reproach
- thoughts about death or suicide
- physical symptoms (pain)
- sleep disturbances
- appetite disturbances

Psychotic symptoms e.g. delusions of poverty, sinfulness or guilt can also occur in severe depressive phases. Hypochondriacal delusions, of being incurably ill, can also appear.

In summary, the symptoms of depression relate to all levels of human existence:
experience and feeling (sadness, despondency, joylessness),
thinking (negative thoughts, catastrophic thinking and loss of concentration),
behaviour and **energy** (social withdrawal and inactivity) and
the **body** (restlessness, sleep disturbances, pain, impaired appetite).

It is important to recognise the early warning signs of a depressive phase. These differ from individual to individual and are often precursors to recurring episodes. It is important that sufferers themselves, or their close relatives, recognise these early warning signs and then seek appropriate therapeutic services. Early warning signs for depression include: lowered mood lasting some hours e.g. in the morning, drop in productivity, difficulty concentrating, becoming easily exhausted, forgetfulness, pain, fitful sleep, loss of interest in hobbies or in meeting other people, problems with motivation, irritability, increased anxiety.

A particular problem encountered in severe depressive episodes is suicidal tendencies (suicidal thoughts or attempted suicide). Warning signs of a risk of suicide are increased withdrawal, neglect, discussion of subjects related to death and methods of suicide and increased alcohol and/or drug consumption. In general, any expression of suicidal thinking should be taken seriously. The popular view that people who talk about suicide won't really do it is very wrong.

Most people who attempt suicide have spoken about it beforehand. Another misconception is that sufferers attempt suicide in order to attract attention - this is at best very rarely the case. It is not uncommon for a suicide attempt to occur at the end of a prolonged period of depressive distress that has not yet been recognised or treated.

In general, whenever suicidal thoughts or suicidal intentions emerge, specialist medical help should be sought.

Manic episodes

Mania is characterised by euphoric high spirits, pronounced, excessive cheerfulness, exuberance, uncritical optimism, exaggerated need for pleasure, loss of self-control and lack of emotional detachment. However, a dysphoric mood with irritability, impatience, discontent and argumentativeness also frequently occurs. Self-confidence is heightened and there is overconfidence, feelings of grandiosity, feelings of superiority and insistence on being right. Energy and activity are elevated, and sufferers have the urge to be busy and display restless movements, starting but not finishing lots of things; thinking and speech are accelerated, sufferers are more easily distracted and their thoughts race. They make unrealistic plans, and their speech is loud and rapid. At a physical level, sufferers display heightened energy and have feelings of immense strength, considerably reduced need for rest and sleep, increased sexual needs with heightened libido and potentially lack of self-control, making impetuous advances. As far as behaviour is concerned, patients with mania are exaggeratedly sociable and enterprising, often careless, are incapable of assessing risks realistically, have a tendency to spend money indiscriminately, tend to excess, make rash decisions, behave in an uninhibited way in public, provoke conflict and arguments and can also become aggressive.

Psychotic episodes can arise if symptoms of mania are strong, frequently in the form of delusions of grandeur, religious mania and erotomania. Hallucinations of both a visual and aural nature can also occur if symptoms are severe.

Patients with mania usually lack insight into their condition, feeling healthier than ever and believing they are on “top form”. In most cases, they also lack understanding of the need for treatment.

In summary, the key symptoms of mania are: increased feelings of self-worth, grandiose thoughts, enhanced creativity, loss of emotional detachment and inhibition, increased energy, garrulousness, increased risk-taking, distractibility, problems with concentration and alertness, decreased need for sleep, increased sexual activity.

Principal symptoms of mania

- ↗ elevated mood for no reason, occasional irritability
- ↗ constant activity and restlessness
- ↗ reduced need for sleep
- ↗ garrulousness
- ↗ loss of social inhibition
- ↗ decreased self-esteem
- ↗ uncontrolled behaviour in relation to money and addictive substances
- ↗ racing thoughts
- ↗ inflated self esteem
- ↗ constantly changing activity
- ↗ foolhardy or reckless behaviour

If the symptoms of mania are less strong and also of shorter duration, we refer to it as “hypomania” (a milder form of mania). Here a slightly elevated mood often lasts for only several days or a few weeks, with the patient noticing increased physical energy and mental creativity.

Hypomania is a moderated form of mania, in which patients are usually still well adjusted socially and have appropriate self-control.

Hypomania does not give rise to psychotic symptoms. Patients often do not notice that they are hypomanic since they experience the state of hypomania as pleasant. Close relatives and friends, however, usually experience the hypomanic symptoms as disturbing and are more likely to notice the symptoms than the sufferer.

Early warning signs of hypomania or mania include exaggerated activity with restlessness and increased industriousness, decreased need for sleep, increased garrulousness, heightened need for contact, difficulties with concentration and becoming easily distracted, and increased irritability. As with the early warning signs of depression, the signs here may differ from individual to individual.

Recognising early warning signs is important in order to identify the start of a recurrence as early as possible in order to be able to access the appropriate treatment.

Mixed episodes

If both manic and depressive symptoms appear within a single phase of illness, then we refer to it as a “mixed” episode.

Here, manic and depressive symptoms alternate within a very short period. Depressive and manic symptoms can also appear together. Thus, the sufferer can, on the one hand, have a depressed mood, but also be lacking in emotional detachment and have heightened energy. Mixed states are difficult to recognise and can often be very distressing for patients.

EXAMINATION (DIAGNOSIS)

There are no laboratory tests which can either identify or rule out bipolar affective disorder or mania. The conditions are diagnosed by observing behaviour, having discussions with patients and their family and friends, asking about current symptoms, previous symptoms and phases of illness, recording trigger factors and potential early warning signs, and undertaking supplementary physical examinations (neurological and internal). Taken together, these measures constitute diagnosis.

Recording family medical history is of crucial importance, too. It is especially important to clarify whether there is a history of depressive or bipolar illness in the family or whether family members have a history of other psychiatric illnesses such as anxiety disorders or addiction. It is important to emphasise the particular significance of family medical history due to the genetic component of bipolar disorder.

Attention must also be paid to any potential for alcohol and/or drug abuse in the patient. Certain medications and drugs can give rise to manic or depressive symptoms.

A particular difficulty is the fact that patients with mania do not feel ill and have no insight whatsoever into the need to consult a doctor. It is often then close family or friends who urge patients to contact a doctor. It is then very helpful if the family member or friend can accompany the patient to the doctor in order to provide information about the behavioural changes they have noticed. It is often close friends and family who first notice changes, for example, increased social withdrawal in depressed patients or an increase in complaints about physical symptoms prior to the episode of illness. Family and friends of manic patients are often the first to notice increased restlessness, sleep disturbances or increased activity. Depressive or manic symptoms, such as changes in energy, activity, mood, sleep, appetite and social or sexual interest, will be investigated during the appointment. Sufferers should also be asked about suicidal thoughts or intentions. Questionnaires can also be used to record depressive or manic symptoms.

If any anomalies are noticed during a physical examination, then it may be necessary to carry out further examinations such as imaging (e.g. taking a sectional image of the brain using computer tomography or nuclear spin tomography). Blood tests should also be carried out, for example, for iron levels, vitamin B12 and thyroid levels, in order to rule out other organic illnesses. Both depression and mania can be the result of organic illnesses which must be ruled out. Discussions with the patient and his/her family members should also clarify whether the patient is currently suffering, or has previously suffered, from other psychiatric illnesses that can often appear alongside bipolar disorder, such as anxiety disorders, obsessive-compulsive disorders, dependency disorders, attention-deficit hyperactivity disorder or eating disorders.

In summary, diagnosis consists of taking the sufferer's medical history (interview), a third-party medical history (interview with family members), recording family medical history, observing behaviour, physical examination and, potentially, additional medical examinations.

As has already been mentioned on a number of occasions, bipolar illness frequently goes unrecognised because (among other things) a detailed case history of the previous phases of illness has not been recorded. We thus feel it is important to emphasise once more the importance of compiling a retrospective record of possible symptoms.

Where bipolar disorder is suspected, the patient should always be referred to a specialist (in Neurology and Psychiatry, in Psychiatry or in Neurology). If the individual is under 18, then a specialist in Paediatric Psychiatry should be consulted. Treatment exclusively by a psychotherapist or psychologist is not appropriate. Psychotherapy should always be undertaken in collaboration with an experienced psychiatrist who is familiar with the symptoms of bipolar disorder.

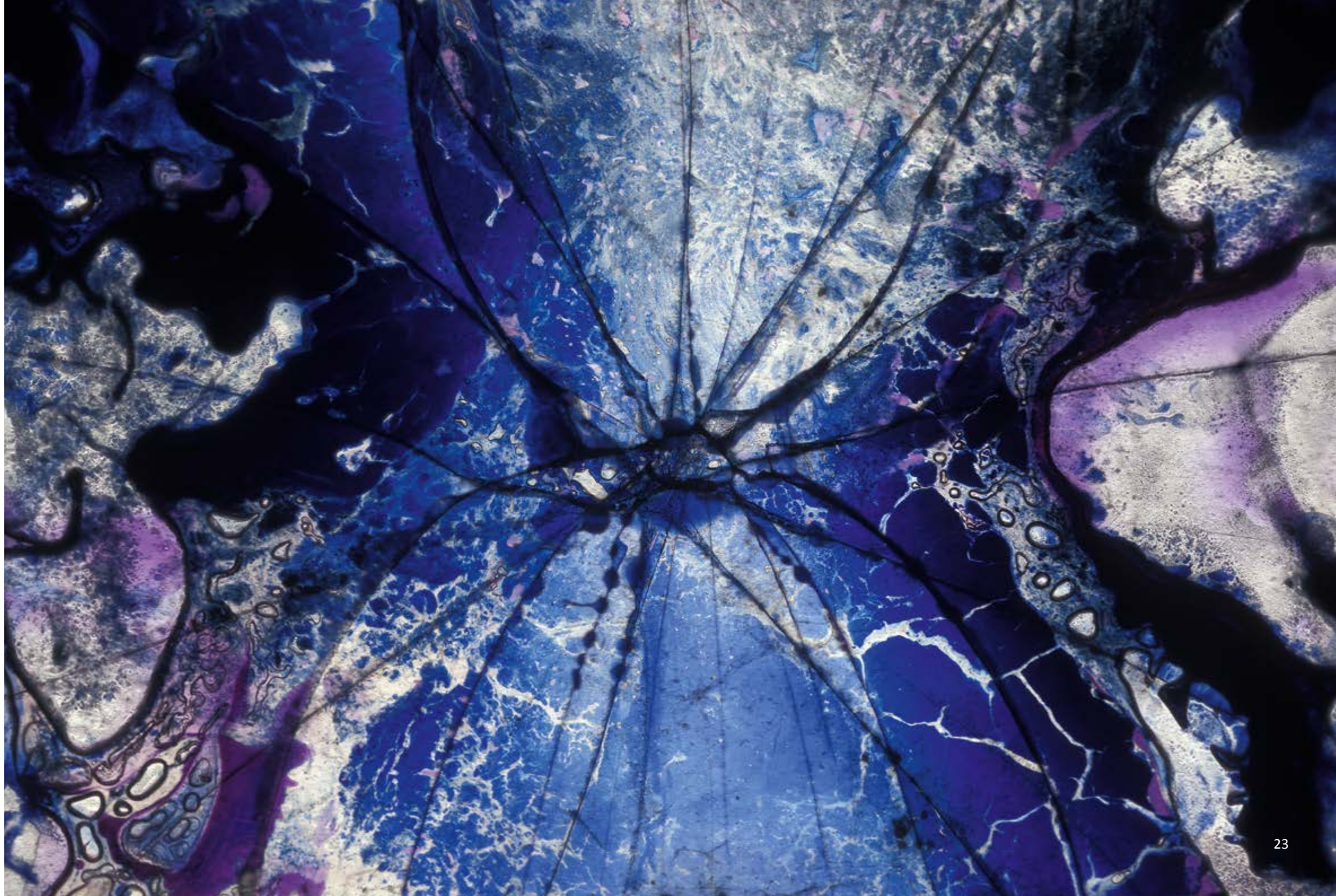
The question of whether examination and treatment should be undertaken on an outpatient or inpatient basis will be discussed again on page 40.

ALONGSIDE WHICH OTHER ILLNESSES CAN BIPOLAR DISORDER APPEAR?

Almost half of those suffering from bipolar illnesses also suffer from other psychiatric illnesses, especially anxiety and addictive disorders. These additional illnesses can come to the fore during healthy periods (as opposed to bipolar episodes) resulting in incorrect diagnostic assessments. Besides anxiety and addiction disorders, eating disorders and obsessive-compulsive disorders can occur, as can attention deficit hyperactivity disorders and personality disorders.

Sufferers are often incorrectly diagnosed with schizophrenia if psychotic symptoms also appear in the course of bipolar phases.

But physical illnesses are also frequently encountered with bipolar illness. Cardiovascular disease, blood sugar and metabolic disorders and migraines are particularly common.



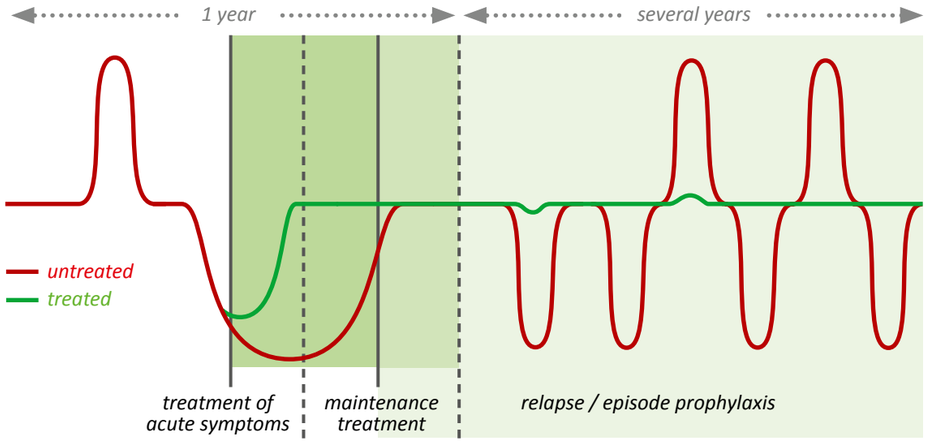
TREATMENT OF BIPOLAR DISORDER

In principle, treatment must be carried out on an individual basis. This applies both to acute and to preventative (prophylactic) treatment. Treatment is always made up of various therapeutic strategies, with medication being a key component. In general, both sufferers and their close family members should be provided with detailed information on and explanation of the clinical symptoms and their progression as well as the planned treatment.

The aim of medication is to normalise the sufferer's mood, energy and sleep-wake rhythm and prevent any recurrence.

Psychotherapy involving close family and friends and psychosocial interventions with the aim of restoring and maintaining social integration and the capacity to learn, train and work are further key cornerstones of treatment.

Stages of treatment



It is crucially important to remember that untreated bipolar illness leads to constantly recurring episodes (relapses) and that there is a risk of suicide (suicidal tendencies), particularly in the context of depressive episodes. It is thus essential to provide detailed information on treatment options for preventing further phases of illness (relapse prophylaxis).

In medication we differentiate between acute treatment, maintenance treatment and relapse prophylaxis.

Acute treatment is intended to minimise depressive or manic symptoms, and is usually administered in the form of medication and associated psychotherapeutic sessions. Maintenance treatment is intended to ensure freedom from symptoms and to reinforce patients' openness to further medication. Here also, ongoing medication and the introduction of psychotherapy are of critical importance. Relapse prophylaxis aims to prevent episodes from recurring and thus to avoid further negative impacts on the sufferer's social and mental development (especially in adolescents and young adults).

The aim is also to lead sufferers and their friends and family to accept the illness. Relapse prophylaxis uses both mood stabilising medication and psychotherapy. The support of self-help groups can also be very useful.

Aims of multimodal treatment

ACUTE TREATMENT	MAINTENANCE TREATMENT	RELAPSE PROPHYLAXIS
• prevention of acute depressive or manic symptoms	• ensure freedom from symptoms • ensure openness to medication	• prevent recurrence of illness • prevent psychosocial impairment • encourage acceptance of illness
• medication • psychotherapeutic sessions • psychoeducation	• medication • psychotherapy / psychoeducation • rehabilitation planning	• mood-stabilising medication • psychotherapy

Medication for manic episodes

The treatment for acute mania is always medication. A variety of medications are available. Which medication to use must always be assessed and decided on a case by case basis.

Lithium

Use:

- ✓ for relapse prophylaxis in bipolar illness
- ✓ for acute mania and as co-therapy for depression
- ✓ to prevent suicide

Please note:

- × Preliminary check-ups and regular check ups thereafter
- × regular monitoring of dosage and intake!
- × potential side-effects: Dizziness, nausea, diarrhoea, increased thirst, trembling, acne, weight gain, thyroid and kidney changes
- × do not discontinue abruptly

For euphoric mania, lithium (e.g. Quilonum retard®, Hypnorex®) is the remedy of choice for treating acute symptoms of mania and for preventing manic episodes. Lithium is an element that occurs in nature as lithium salts. Lithium treatment requires precise dosages and must be taken carefully. Tests are necessary before lithium treatment can begin.

Regular monitoring is required when lithium is being administered. Kidney and thyroid function must in particular be checked. Blood samples must be taken on a regular basis at the start of treatment to measure the concentration of lithium in the blood; later these can be carried out at greater intervals. Trembling of the hands, tiredness, dizziness, nausea and diarrhoea frequently occur when lithium treatment is started. The symptoms usually diminish in intensity as treatment progresses. For the treatment of acute mania, the lithium concentration in the blood should be between 1.0 and 1.2 µmol/l, and for prophylactic treatment (relapse prophylaxis) the lithium concentration should be 0.6 to 0.8 µmol/l. If the lithium concentration is exceeded (e.g. as a result of taking too much lithium), symptoms of poisoning (intoxication) can occur. In order to prevent such issues, lithium should be taken in the exact amounts recommended by your doctor.

Regular checks (approx. 3-4 per year) must be carried out, in particular of kidney and thyroid levels. Lithium excretion is restricted in cases of fever or diarrhoea, where large amounts of electrolytes (e.g. sodium, potassium and calcium) and water are lost from the body, which can result in a high concentration of lithium in the blood. Profuse sweating (on holiday in hot countries, in saunas or during intense physical activity) can also result in a high lithium concentration in the blood. A low salt diet can be dangerous. An adequate intake of water and salt must be ensured at all times. Certain medications (e.g. diuretics and pain relievers such as ibuprofen or diclofenac) can also be dangerous. Before you take additional medication, it is essential that you ask your doctor whether it is compatible with lithium. In general, lithium should not be abruptly discontinued.

Anticonvulsives (carbamazepine, valproate and lamotrigine) and/or antipsychotics can potentially be administered as alternatives to lithium.

Carbamazepin (e.g. Tegretal®, Timonil®) was originally used to treat epilepsy but also has an antimanic and prophylactic effect. Monitoring of blood levels is also required here.

Side effects can include tiredness, unsteady gait, lack of appetite, nausea, vomiting, allergic skin reactions and changes in liver levels and blood count. Due to the side effects, carbamazepine should only be administered as a second or third choice if there is no response to lithium or if lithium is not tolerated. Carbamazepine can also be combined with lithium, although this can result in increased side effects. In general, the potential for numerous interactions with other medications and with food (e.g. grapefruit juice) can occur and must be taken into account when administering carbamazepine.

Valproate (or valproic acid, e.g. Ergenyl®, Orfiril®) is another, newer alternative to carbamazepine which can also be used for treatment of acute mania and for relapse prophylaxis (in men only, however). Valproate is a potential alternative, especially in cases of “rapid cycling” - the special form of bipolar progression - where lithium is not effective. Possible side effects of valproate include gastrointestinal complaints, trembling, tiredness, weight gain, hair loss and changes in liver values and blood count. Acute pancreatitis can also occur so that this side effect must be considered if there is a sudden onset of abdominal pain. Regular monitoring of pancreatic enzyme values is essential.

Another anticonvulsive drug that represents a possible treatment option for relapse prophylaxis is **lamotrigine** (e.g. Lamictal), which is particularly effective for the treatment of depressive episodes but less so for episodes of mania. The dosage is 200 mg/day, occasionally increased to 300 mg/day. Tolerance is generally good with common side effects including joint pain, dizziness and allergic skin reactions. Rarely, life-threatening skin reactions can arise in the event of rapid increases in dosage (comply with SPC!) or administration in conjunction with valproate or carbamazepine.

A further alternative is **antipsychotic drugs**, which can be used to treat acute mania but also to supplement relapse prophylaxis that has already been started with lithium and/or lamotrigine or valproate. The administration of antipsychotics increases the effectiveness of relapse prophylaxis. The newer antipsychotics (known as second generation neuroleptics or atypical antipsychotics) in use include, for example: aripiprazole (Abilify®), asenapine (Sycrest®), olanzapine (Zyprexa®), quetiapine (Seroquel®, Seroquel Prolong®), risperidone (Risperdal®) and ziprasidone (Zeldox®). These medications can also give rise to a range of side effects and appropriate tests are required.

Which medication or combination of medications is used must always be an individual decision that you should discuss with your doctor.

Medication for bipolar depression

Treatment of bipolar depression (a depressive episode as part of bipolar disorder) makes a fundamental distinction between medication and non-medication strategies. Medication uses antidepressants, mood stabilisers or atypical antipsychotics.

Mood stabilisers should in principle be the basic medication for treating bipolar illness. Mood stabilisers alone are often sufficient to treat milder depressions.

The effectiveness of **lithium and quetiapine** (an atypical antipsychotic) have been most thoroughly researched. Quetiapine has a predominantly antidepressant but also antimanic effect. Lithium has both an antimanic and antidepressant effect and is the only medication administered for bipolar illness; it also has an „anti-suicidal“ effect i.e. it can reduce suicidal thoughts or intentions (suicidal tendencies). This is particularly important since suicidal tendencies are particularly high in patients with bipolar disorder. For potential side-effects, blood level monitoring and regular check-ups, see pages 28/29.

The anticonvulsive **lamotrigine** is also as a potential alternative for bipolar depression. Lamotrigine is especially useful as a mood stabiliser for relapse prophylaxis when the intention is to prevent further depressive episodes. It is important to increase the dosage of lamotrigine very slowly since otherwise dangerous allergic skin reactions can occur (see above).

In summary, if bipolar depression is present, patients should initially be switched to quetiapine or a mood stabiliser. If this is not sufficient on its own, then in the event of serious bipolar depression, short-term medication with an antidepressant is also appropriate.

A dreaded complication in treatment with antidepressants is the so-called switch risk, which refers to the switch from depression to mania that can be triggered by antidepressants. “Old” antidepressants, such as tricyclics, had a particularly high switch risk. These should therefore be avoided in favour of selective serotonin reuptake inhibitors (SSRI) e.g. sertraline or citalopram / bupropion, which have a relatively low switch rate. An alternative antidepressant treatment is represented by the so-called MAO inhibitors such as tranylcypromine or moclobemide, which also have a low switch rate.

Maintenance treatment should continue for at least six months following acute treatment to prevent any risk of relapse. Long-term antidepressant medication is required if depressive symptoms continue to recur. However,long term medication also risks triggering a switch to mania.

Psychotherapeutic treatment for bipolar depression is discussed on page 34.

Medication for manic-depressive mixed states

The treatment of manic-depressive mixed states presents a particular challenge since episodes involve frequent switches between manic and depressive symptoms. Antidepressants should be avoided as much as possible since they can exacerbate mixed states. The use of valproate and olanzapine has been the most thoroughly investigated, and carbamazepine is also an alternative. If necessary, a range of combination therapies can be used, e.g. lithium + carbamazepine or lithium + valproate, carbamazepine + valproate or lamotrigine + carbamazepine. Alternatively, mood stabilising medication can be used with second-generation antipsychotics, for example lithium + quetiapine or olanzapine.

Preventative treatment (relapse prophylaxis)

As we have already repeatedly emphasised, bipolar illness is usually a lifelong illness that manifests as recurring episodes and requires long-term treatment. Preventative medication should be begun immediately after the first phase if the initial episode is severe or involves suicidal tendencies, or if there is a family predisposition to bipolar illness. In other cases, relapse prophylaxis should be started after the second episode. The objective of long-term treatment is to avoid the repeated recurrence of depressive or manic phases. The objective of relapse prophylaxis is, in addition to preventing recurring episodes, to ensure that patients are symptom-free and do not suffer psychosocial impairment (professional training, job, family integration). Preventative treatment of bipolar illness is long-term, and in many cases may even be lifelong.

Long-term treatment of bipolar illnesses involves mood stabilisers such as lithium, carbamazepine, valproate and lamotrigine. Second-generation antipsychotics (atypical antipsychotics) may also be used.

Medication is selected on a case by case basis, taking account of which medications have proved effective during acute or maintenance treatment, or have previously been effective for the sufferer or even the sufferer's friends and family; which medications have been well tolerated and if they have been successful in preventing phases from recurring. Taking medication regularly and reliably of course requires the patients to have accepted their illness. Attention must also be given to which other mental or physical illnesses are present in the patient and whether there is a risk of suicide.

Lithium represents the gold standard or drug of first choice for relapse prophylaxis in relation to bipolar disorder. It is the only mood stabiliser that also has a separate "anti-suicidal" effect in addition to its antimanic and antidepressant effects. Lithium is especially effective in treating typical manic-depressive progressions. It requires a high degree of compliance with treatment as regards medication. For blood level monitoring, potential side effects and regular check-ups, see pages 28/29.

In the event of lithium being ineffective or not tolerated, alternatives are valproate and carbamazepine, especially for patients with "rapid cycling" or manic-depressive mixed states. For monitoring and potential side effects, see pages 28/29. Lamotrigine is another alternative for the prevention of depressive episodes in the context of bipolar illness. We would like to emphasise here again the importance of increasing the dosage slowly since rapid increases can lead to dangerous skin reactions.

Other potential medication strategies for relapse prophylaxis are the atypical antipsychotics olanzapine, quetiapine, ariprazole and risperidone (see above). For the appropriate check-ups, see page 29.

Psychotherapy and psychoeducation

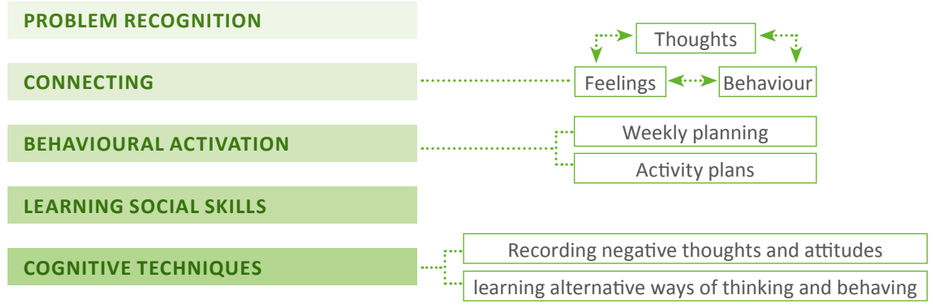
The aim of **psychotherapy** in relation to bipolar disorders is to have an impact on the various aspects of the illness, in particular with a view to enabling sufferers to recognise stressors in a timely manner and process the emotional problems of the illness, the fear of relapse, issues of stigmatisation resulting from the illness and the attendant social consequences and impairments.

The focus is on regularising social rhythms (e.g. regular sleeping patterns, no shift work, see below). A range of psychotherapeutic approaches are used, such as interpersonal psychotherapy, cognitive behavioural therapy and family therapy. Issues dealt with in the various therapeutic procedures include stabilisation strategies, recognising stressful life events, remedying sleep disturbances and the problems of lifelong medication.

The emphasis on stabilising social rhythms is of critical importance. Priority is given to stabilising the sleep-wake rhythm, in particular with the aim of achieving regular and sufficient sleep. The process identifies factors which disrupt sleep, such as shift work, irregular working habits or the pressure of deadlines.

It is necessary to stay active and maintain a daily routine during depressive phases and reduce stimulation during phases of hypomania or mania. Recognition of early warning signs is important for prevention: sleep disturbances often precede a depressive phase, for example.

Treatment phases in behavioural therapy



Psychotherapy is concerned with the recognition of individual early warning signs and the practice of appropriate self-awareness. Behavioural therapy teaches techniques for reducing thinking and behaviour that promote depression. A range of relaxation techniques to reduce stress can also be learnt. In addition to psychoeducation and sharing the vulnerability-stress model, discussions in family therapy cover early warning signs, improving compliance with medication treatment and reducing stress by decreasing conflict and improving communication within the family.

The aim of **psychoeducation** is to provide patients and their family and friends with information on the illness, the different explanatory models and on treatment strategies. The focus is on prevention of recurrence (relapse prophylaxis). Acceptance of the illness and insight into the need to take preventative medication are crucial here. The better informed patients and their family and friends are, the better able they are likely to be to work together and accept the illness.

Psychoeducation also covers how to process pressure and stress factors and what potential coping strategies might be; it also teaches self-awareness and the ability to recognise early warning signs in good time and to use appropriate crisis management techniques if necessary.

Objectives of psychotherapy and psychoeducation

- ✓ Rebuilding daily routines
- ✓ Developing a balanced daytime and night-time rhythm
- ✓ Developing activities during periods of depression
- ✓ Reduction of stimuli during periods of mania
- ✓ Improving social competence
- ✓ Coping with the illness
- ✓ Recognition and reduction of individual stress factors
- ✓ Recognising situations that trigger relapses

Psychotherapy and psychoeducation bring patients and their family and friends to a better understanding of the illness, reduce stressors and help them learn coping strategies to deal with the illness. They also promote insight into the importance of regular medication. Topics covered include daily routine, planning of activities and recovery phases, and relaxation options. Psychotherapy and psychoeducation can be used to supplement relapse prophylaxis medication for bipolar illnesses to help avoid frequent relapses and to promote symptom-free intervals.

Supplementary treatment strategies

Light therapy

Light therapy is particularly helpful for seasonal affective depression

This takes the form of depressive phases that occur in the autumn and winter months and include characteristic symptoms that are designated “atypical”, such as increased need for sleep, a ravenous appetite for carbohydrates, increased appetite and weight gain. Light therapy is recommended for patients with seasonal affective mood swings.

It should be administered for 30 minutes at a light intensity of 10,000 lux, preferably in the morning. In certain circumstances, light therapy can be recommended throughout the winter. There are as yet few studies on the effectiveness of light therapy for bipolar depression. However, it can be used to supplement treatment in this context.

Sleep deprivation (wake therapy)

Wake therapy (sleep deprivation) can be considered in cases of depression, including bipolar depressive illnesses.

Patients who tend to experience daily mood swings with morning lows respond particularly well to sleep deprivation. However, the effect of sleep deprivation treatment is usually short term and disappears after the following night’s sleep. The therapy can, however, be repeated several times (2-3 times per week).

Patients who suffer from seizure disorders in addition to bipolar depression should not be treated with sleep deprivation.

A side effect of sleep deprivation therapy is the risk of triggering a manic episode, particularly in bipolar patients with rapid cycling.

Electroconvulsive therapy (ECT)

Electroconvulsive therapy is effective both with bipolar therapy and with manias.

It is primarily used to treat depressive episodes which have not responded (or have responded inadequately) to psychotherapy. Electroconvulsive therapy is especially indicated for delusional depressive illnesses. It is also recommended for strong depressive episodes involving refusal of food and liquids.

The therapy is carried out solely in specialised centres. High safety standards and strict supervision of anaesthesia are always essential. Electroconvulsive therapy is a safe procedure if the appropriate supervision requirements are complied with.

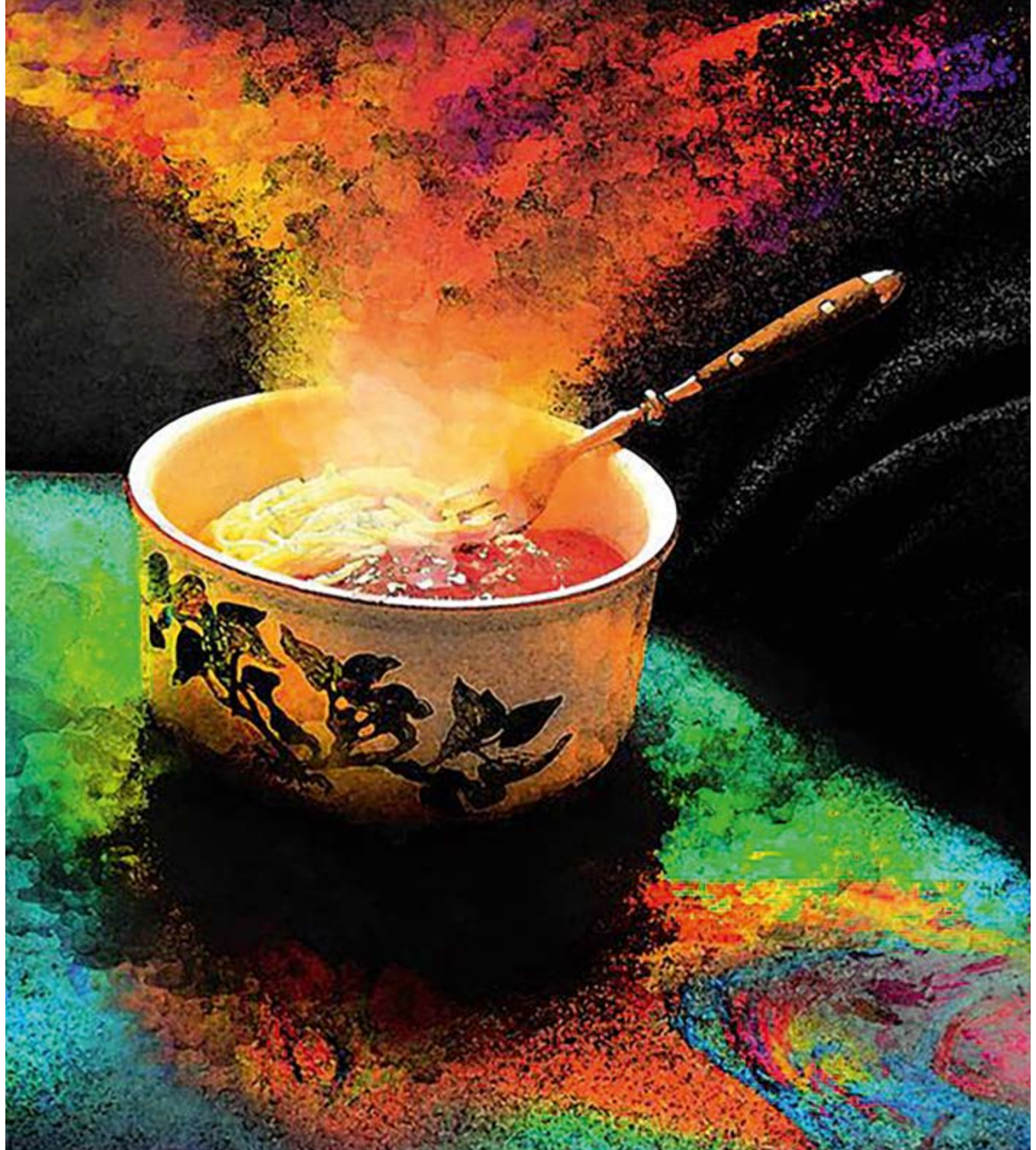
Lifestyle - nutrition and sport

Our nutrition and our enjoyment of movement have a great influence on our physical and mental well-being. Many patients experience considerable weight gain when taking psychotherapeutic drugs. Bipolar can itself also lead to negative changes in the metabolism of sugar and fats.

Excess weight not only has an impact on feelings of self-worth, it can also trigger serious physical problems. It considerably increases the risk of developing diabetes and cardiovascular disorders such as high blood pressure. For this reason, it makes sense to reduce your individual risk of illness through a balanced diet and regular exercise. Regular exercise not only improves physical health, it also has a proven antidepressant effect and increases energy levels. It will ensure you have more energy to cope with your problems.

Nutrition

Psychotherapeutic drugs in themselves do not make you fat. However, the metabolic changes triggered by certain psychotherapeutic drugs, along with their sedative effect, can lead to reductions in basal metabolism and increased calorie intake as a result of ravenous hunger. The consequence is a significant increase in body fat percentage. If this happens you can discuss with your doctor whether alternative drugs could potentially have less pronounced side effects.



What is good nutrition? There is not one single type of nutrition that will deliver the desired success for everyone. You should always consider and decide for yourself what type of nutrition best suits your needs.

Sport and physical activity

Regular exercise and sporting activities should be an integral part of life. In addition to the physical benefits of sport such as strengthening joints and bones, building up muscle mass and training the cardiovascular system, it has a proven impact on depressive moods. Together with a balanced diet, the appropriate amount of sport is a good way to improve your health in both the short and the long term. In endurance sports, you should select types of sport that are gentle on the joints such as swimming, cycling, power walking or hiking. The level of intensity is less important here. What is important is that you take regular exercise, get out into nature and enjoy some natural sunlight. Even power walking or strolling for thirty minutes twice a week delivers proven health benefits. You should have yourself examined by your GP as a precautionary measure before doing any intensive sport so that any cardiovascular illnesses or other risk factors can be identified. In addition to sport you should pay attention to recuperation.

Outpatient or inpatient treatment

The question of inpatient treatment comes up in emergency situations that can sometimes occur with bipolar disorders due to the severity of symptoms. Such emergency situations can arise as a consequence of severe depression with suicidal tendencies (suicidal thoughts and attempts). Patients with depression or suffering from manic-depressive mixed states generally present with a risk of suicide. It is wrong to believe that people who talk about suicide won't follow through. Indications of a suicide risk include previous suicide attempts, suicide or suicide attempts by relatives, ongoing suicidal thinking or expression of the desire not to live any more, planning a suicide attempt, delusional symptoms with feelings of guilt or sinfulness, aggression, restlessness, expressing a feeling of being a burden to family and friends, feelings of worthlessness, the desire for peace, social withdrawal, declarations of hopelessness.

Inpatient treatment is usually necessary in the event of suicidal tendencies. Inpatient treatment is often required for manic symptoms where insight into the illness is often missing, in order to shield patients from stimuli. If the affected patient does not consent to inpatient treatment despite it being considered necessary by a specialist, then, assuming that they are a danger to themselves or to third parties, inpatient treatment against the will of the patient may be required. An enduring power of attorney can be very helpful. This is a declaration of consent on the part of the sufferer, made during a healthy period, in which he/she grants a person he/she trusts the right to make decisions on his/her behalf during acute phases of the illness, for example an enduring power of attorney relating to healthcare, asset management or decisions regarding the place of residence. Patients and their family and friends should come to an agreement during healthy periods about who the patient or family and friends can contact in crisis situations. This so-called crisis plan assists with obtaining help as quickly as possible in an emergency situation and includes contact persons with phone numbers and availability (e.g. phone number of the attending doctor, emergency services, the nearest specialist hospital).

Inpatient treatment in the event of:

- pronounced symptoms
- physical impairment
- danger to self or others
- outpatient options are exhausted
- lack of response and resistance to medication

AN ACTIVE APPROACH TO BIPOLAR DISORDER

It is of crucial importance for positive progression with the illness that patients and their family and friends succeed in moving from passive "suffering" to an active and open approach to bipolar illness.

Despite and precisely because of the multiple stresses the illness causes for patients and their family and friends, it is crucial that sufferers find out about bipolar illness and actively engage with its consequences. The strategies for coping with illness mentioned in the chapter on psychotherapy and psychoeducation above are important aids in this process.

In addition to these, it is often very helpful to exchange experiences within psychoeducational groups, which are usually led by professional helpers. Both sufferers and family members can gain a great deal of relief from learning that others struggle with similar troublesome feelings and problems as a result of the illness, and from exchanging specific tips on how to cope (see chapter on self-help and trialogue below). The relevant addresses and contact names are available from the website of the Deutsche Gesellschaft für Bipolare Störungen [German Society for Bipolar Disorders] **(www.dgbs.de)** and via the Bundesverband der Angehörigen psychisch kranker Menschen [The Federal Association of Families of People with Mental Illness] **(www.bapk.de)**.

Since mental illnesses are still not as accepted in society as physical illnesses, it is especially important that sufferers receive support in dealing with the everyday stresses resulting from the illness. These include, in particular, dealing with the lack of information about the illness and the treatment options, lack of institutional support, disadvantages in working life and experience of stigmatisation and prejudice in the social context.

Sufferers also need emotional relief. They are often burdened with fears about the future, loneliness and hopelessness, feelings of guilt, shame and embarrassment, as well as grief for life goals that are no longer attainable. It is only when sufferers find the courage to discuss these feelings and their problems openly, e.g. following the example of other sufferers in support groups, that they will access this support.

SELF-HELP AND TRIALOGUE

In addition to having a trusting and cooperative relationship with their doctor and/or therapist and taking the prescribed medication regularly and consistently, there are also other ways of achieving sustainable improvements in patients' state of health. These can be summarised by the key phrases "self-help" and "support for self-help". They share the common feature that they can be accessed and administered at any time.

The self-help movement arose out of support groups. Support groups are still a central feature of self-help and are a key component in the care of people with mental illnesses and their family and friends. Nowadays there are also many internet based virtual support groups in the form of forums, chats and messenger networks. They provide an important supplement to in-person support groups and useful alternatives for people who cannot attend local support groups. Lifestyle issues such as healthy eating, sport and sleep habits are gaining increased traction as self-help options. Many patients experience considerable weight gain due to medication. Changes in diet, along with sport, can result in improvements in mood, increased energy levels and weight loss. They can also improve sleep, which has frequently been disturbed, and not least help prevent secondary illnesses such as diabetes (diabetes mellitus).

It is useful to research as many aspects of bipolar disorder and the various treatment methods as possible. As your knowledge of the illness grows, so does your understanding of the progression of your own illness. You may discover treatments that you have not yet considered and discuss them with your doctor.

Doctor patient discussion is of crucial importance, as is communication with family and friends, since they have an important role to play, especially in acute crises and crisis management. It is important that your doctor is aware of all relevant information on your health status. This is the only way that he/she will be able to give you appropriate professional advice and determine the correct medication for you. Successful doctor-patient communication is a basic prerequisite for successful treatment. Family members can also provide useful information that the patient may have decided is not worth mentioning but which is significant for the doctor.

Support groups

Local support groups are the central component of self-help. They are a key point of contact,and are experienced as supportive and helpful by those who have just been diagnosed, long-term sufferers and family and friends alike. A list of bipolar support groups in Germany can be found on the DGBS website under the heading “self-help”.

For sufferers

Those suffering from the illness find it very helpful to be able to compare notes with other people who are also affected by the illness. Exchanging views with other sufferers helps to develop illness management skills. Learning from and with others is an integral feature of support groups. Even very personal and intimate issues can be discussed there. Meetings usually last 90 to 120 minutes and take place at intervals of between once a week and once a month. On average, groups consist of between 6 and 10 participants. Issues discussed remain within the group and are not brought outside.

In crisis situations, a support group can be a helpful and stabilising element that may ensure the crisis resolves more rapidly and may even shorten the duration of stay in a clinic. Participation in a support group promotes new social contacts and often leads to friendships. Sufferers’ understanding of the illness can be enhanced by participating in a support group. People who have only recently been diagnosed with bipolar disorder can benefit from the experience of long-term sufferers.

For family members

The role played by family members in the treatment of bipolar disorders is unfortunately still insufficiently appreciated in everyday psychiatric treatment. If a partner, son, daughter or parent becomes ill, family members often feel inadequately supported and insufficiently involved in treatment. They are just as burdened by the psychosocial and financial chaos that is frequently caused by mania and depression. This is exacerbated by feelings of responsibility for the sufferer. In this situation it can also be advisable for family and friends to join family and friends support groups. These are special support groups made up of and run for family and friends, where the same rules apply as in the groups for sufferers. In the groups, family and friends can learn how to deal better with their partner’s, child’s or parent’s illness and how to support them more effectively. They can also learn how to distance themselves and to recognise in good time when it would be better to pull back.

Virtual support groups

Virtual support options on the internet such as discussion forums and chat-rooms can be a good alternative if sufferers have no opportunity to attend a local support group or reservations about outing themselves in a group. They can also act as a useful supplement to attending a support group in person. Many people find it easier to talk about personal and stressful topics under the cover of a pseudonym. And writing itself has a therapeutic effect for many people and supports self-reflection.

Forums

Discussion forums on the internet are the most popular form of virtual support. There are support forums for practically every illness. Alongside discussions with the attending doctor, they are an important source of information for many sufferers and their family and friends and a platform for exchanging views with other sufferers or family and friends. Their anonymity facilitates open and uninhibited exchange. Anyone posing a question will usually receive useful answers within a few hours due to the large number of participants. Exchanging information with other sufferers or family and friends is rewarding and has similar effects to attending a support group in person. It reinforces self-competence by increasing knowledge about the illness and treatment strategies. Virtual friendships also frequently arise which can result in face to face meetings. The use of pseudonyms avoids personal information being linked with real-life individuals. The knowledge and experience of the many participants is a great strength of internet forums. Helpful answers are usually available to even the most specific questions. At the same time, the extensive archives, where all frequently asked questions have been already repeatedly answered, can be used for research. When participating in support forums, do remember that communication can sometimes be unrestrained and direct as is the case everywhere on the internet. This means that extremely emotionally stressful situations may arise. Depending on your resilience, this can either train you to handle conflicts or apply excessive, unhealthy strain. In this case it is advisable to seek out other chat rooms or to distance yourself until such time as you can again deal with the situation in a composed way.

Chats and instant messenger

Chat rooms and instant messengers such as Skype or ICQ facilitate direct and immediate discussion. A chat can be organised in the same way as a support group with traditional support group rules, where the participants meet, for instance, once a week at a particular time. There are also public chats where in principle anyone can take part. As a rule, participation in forums and chat rooms will again and again result in private chat contacts. Instant messengers such as Skype or Whatsapp are used for this. Such contacts can be an important support in coping with the illness.

Risk of addiction

You should generally ensure that you do not shift your social life completely into the virtual world. Virtual contacts and successes are easier to achieve than real-life contacts and successes in the real world. Real social activities should always be prioritised over virtual activities. Escaping into virtual worlds, however real they may seem, does not solve pre-existing real-life problems.

WHAT SUPPORT CAN FAMILY AND FRIENDS PROVIDE?

Many of the problems mentioned are also a burden on the sufferer's family and friends. **It's not just the person with the bipolar illness who suffers as a result of the illness and its consequences, the whole family is affected.** It is often precisely immediate family members who first notice changes due to the illness and instigate the first visit to a psychiatrist.

However, it's not just in recognising illness symptoms that family and friends play a crucial role. They also frequently provide important support to sufferers in the course of the illness and in particular help with avoidance of relapses. They are often the first to sense changes in mood and/or energy in their affected relative or friend and can thus prompt a visit to a therapist in good time and help prevent serious relapses. When the sufferer is in a depressive phase, family and friends often try to mitigate the sufferer's social withdrawal with increased presence and attention.Sufferers' manic phases often drive family and friends to the limits of their capacity in other ways. It is helpful for family members to become aware that both verbal criticism and even physical assaults from the sufferer are symptoms of his/her illness and should not be misunderstood as personal attacks. It is particularly stressful when there is a need to inform the doctor of a sufferer being a danger to themselves or others, resulting in a patient's involuntary admission to a clinic. In order to make such exceptional situations easier, it is very helpful if a crisis plan is drawn up during a period when the sufferer is well. This emergency plan records which early warning signs have been observed in previous manic/depressive episodes, which doctor/clinic the sufferer would like to be treated by in the event of a recurrence of crisis, which medication was helpful in previous crises and which was not, and what the family and friends should do, for example during a new manic episode.

Moreover, family and friends can support the sufferer by reducing excessive stress, which it has been shown can be a contributory trigger for new episodes. Possible stressors in this context can be persistent problems within the family, stressful styles of communication and also irregular sleep-wake rhythms and lack of daily routine. Relatives can support their family member by adhering to a regular night-time sleep routine and developing balanced daytime activities with sufficient recovery periods. Both over-protectiveness with release from all everyday tasks and excessive demands are stressful for sufferers. Then again, family and friends are burdened with the issue of whether their affected family member or friend is no longer able to deal with certain tasks or no longer wants to deal with them (the mad or bad issue). Here, open and honest discussion can avoid stressful misunderstandings. Moreover, family members must take care of themselves so that they know their limits as far as support is concerned and are able to feel good about ensuring they keep doing good things for themselves as well. Only someone who is looking after themselves will be capable of providing stable support to a sufferer.

HELP FOR SUFFERERS FROM FAMILY AND FRIENDS

✓ recognising symptoms of depression and mania ✓ early recognition of sufferers' individual early warning signs ✓ encouraging specialist treatment ✓ supporting compliance with treatment plan ✓ reducing internal family stressors ✓ supporting balanced daily routines and regular sleep at night ✓ encouraging social contacts ✓ support for (selected) open approaches to the illness ✓ protecting the acutely ill ✓ discussing and adhering to the crisis plan ✓ alertness with regard to drug consumption (alcohol, other intoxicants, etc.)

CHILDREN OF PEOPLE WITH BIPOLAR DISORDER

Due to their natural dependence, the children of people with mental illnesses are the family members who are most affected by it and yet even today they are still often overlooked by professional support providers and society.

The children of people with bipolar disorder can be affected by a range of psychosocial stresses:

- Suffering as a result of the parent's changed behaviour due to the illness, which can lead from decreased awareness of the child's interests, to extreme shifts by the parent between devotion/love and rejection, to becoming involved in the sufferer's delusions or high-risk behaviour.
- Fears for an ill mother/father, fear of an ill parent, fears for the future with regard to the affected parent or for their own future, fear of becoming ill themselves, fear of passing on the illness to their own children (this can extend to loss of the desire to have a child) and existential fears with regard to low family income.
- Being solely responsible, taking on tasks/responsibilities which are not age-appropriate in respect of the ill parent/younger siblings (parentification).
- Feeling of guilt and shame, helplessness and powerlessness, despair and loneliness which can be further exacerbated by "secrecy rules" within the family ("this illness is not the business of anyone who's not in the family") and can promote social withdrawal
- (traumatising?) experiences of loss e.g. in the event of acute clinic admissions
- experience of exclusion and stigmatisation
- These manifold stresses lead to a range of psychosomatic symptoms such as headaches, stomach pains, problems with concentration in school.

Because of this, the children of people with bipolar disorder need a wide variety of low-threshold support services. To enable children to receive any support at all, their parents first need information and the confidence that the children will not be taken away, but rather will be provided with the best possible support in discussion with them. Children have extremely fine antennae for changes in the behaviour of their parents and a vivid imagination as far as the reasons for such changes are concerned. Hence, they need to be given (repeated) confirmation that it is not their behaviour that has caused their parent's illness. Children must be given an explanation of their parent's illness in child-appropriate language. They need tips for dealing with the sufferer and help in dealing with stigmatisation by friends of the same age. They need to be given "permission to be children" again and to cede responsibility to other (institutional) support providers.

Especially in the case of single parents, a familiar contact person must be consistently available to the child during acute phases (sponsorship). Exchanging experience with other children of people with mental illnesses can also enable children to learn more self-confidence and discover a more open way of dealing with the illness. The Federal Working Group on Children of Parents with Mental Illnesses also provides good information on this (www.bag-kipe.de).

The aim must be to impart stability and confidence to the child despite the parent's illness. Finally, the children of bipolar parents need, like all children, the absolute confirmation that they are loved even if the ill parent is not able to show their love during acute phases.

Protective factors for children

ENVIRONMENT	INDIVIDUAL FACTORS child's resilience
• support for the child from other family members (e.g. grandparents) • a stable home • stable relationships in the family and circle of friends • support from doctors/teachers	• even temperament • sociability • social skills • physical activity • good self-confidence • problem-solving ability • assertiveness • their own interests

RECOMMENDED READING

HANDBOOKS

Peter Bräunig
Leben mit Bipolaren Störungen [Living with bipolar disorders]
Publisher: Trias ı Revised edition 2018

Monica Ramirez Basco
Manie und Depression – Selbsthilfe bei Bipolaren Störungen
[Mania and depression - self-help for bipolar disorders]
Publisher: Balance Buch + Medien ı Revised edition 2017

Daniel Illy
Ratgeber Bipolare Störungen: Hilfe für den Alltag
[Bipolar disorders handbook: help for everyday life]
Publisher: Urban & Fischer ı 2016

Janine Berg-Peer
Aufopfern ist keine Lösung:
Mut zu mehr Gelassenheit für Eltern psychisch erkrankter Kinder
[Self-sacrifice is not the solution: the courage to be calmer for parents of children with mental illness]
Publisher: Kösel ı 2015

Candida Fink & Joseph Kraynak
Manisch-depressiv für Dummies [Manic depression for dummies]
Publisher: Wiley VCH ı 2009

Thomas Bock
Achterbahn der Gefühle: Mit Manie und Depression leben lernen
[Emotional roller coaster: learning to live with mania and depression]
Publisher: Balance Buch + Medien ı 2007

SPECIALIST BOOKS

Michael Bauer (Ed.)
S3-Leitlinie Diagnostik und Therapie Bipolarer Störungen
[S3 guidelines for the diagnosis and treatment of bipolar disorders]
Publisher: Springer ı 2013 (in revision)

BIOGRAPHIES AND NOVELS

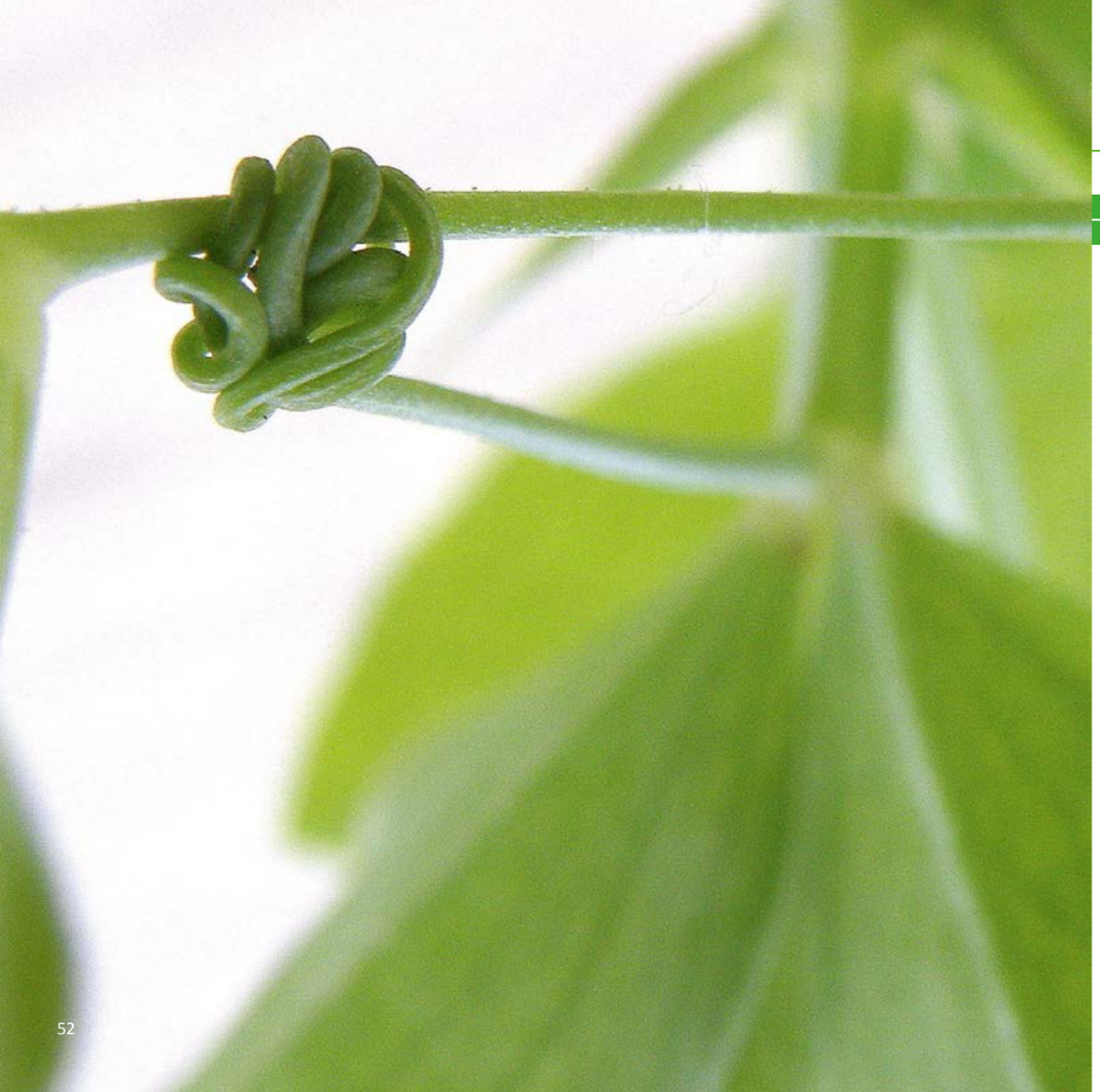
Thomas Melle
Die Welt im Rücken [The world at your back]
Publisher: Rowohlt Berlin ı 2016

Kay Redfield Jamison
Meine ruhelose Seele: Die Geschichte einer Bipolaren Störung
[My unquiet mind: The story of a bipolar disorder]
Publisher: mvg ı republished 2014

Sebastian Schlösser
Lieber Matz, dein Papa hat 'ne Meise:
Ein Vater schreibt Briefe über seine Zeit in der Psychiatrie
[Dear Matz, your Dad is mad: a father's letters about his time in psychiatric care]
Publisher: Ullstein ı 2012

A detailed list of handbooks and specialist books is available from our website:

www.dgbs.de



ADRESSES

Deutsche Gesellschaft für Bipolare Störungen e.V. (DGBS)

Head Office postal address:
DGBS · Psychiatric Clinic
Heinrich-Hoffmann-Str. 10 · 60528 Frankfurt/M
Germany

Tel.: +49 (0)69 / 630 184 398

Email: info@dgbs.de
Website: www.dgbs.de

Telephone counselling for sufferers, their family members and professional therapists:
0800 / 55 33 33 55
(12 Cents/Min. from German landlines, fees from mobile networks vary)

Monday	10:00 a.m.	to	1:00 p.m.
Tuesday	2:00 p.m.	to	5:00 p.m.
Wednesday	3:00 p.m.	to	6:00 p.m.
Thursday	5:00 p.m.	to	8:00 p.m.
Friday	10:00 a.m.	to	1:00 p.m.

Self help for families (Bundesverband der Angehörigen psychisch kranker Menschen (BAPK), The Federal Association of Families and Friends of People with Mental Illness)

Oppelner Straße 130 · 53119 Bonn, Germany
Tel.: +59 (0)228 / 710 024 00
Email: bapk@psychiatrie.de
Website: www.bapk.de

Federal association Kinder psychisch erkrankter Eltern [Children of parents with mental illness]

Email: kontakt@bag-kipe.de
Website: www.bag-kipe.de

Addresses for support groups for people with bipolar illness and their family members:

on the Deutsche Gesellschaft für Bipolare Störungen e.V. website www.dgbs.de
By telephone: +49 (0)69 / 630 184 398

NAKOS: National Contact and Information Office for the Promotion of Support Groups

Otto-Suhr-Allee 115 · 10585 Berlin, Germany
Tel.: +49 (0)30 / 31 01 89 60
Email: selbsthilfe@nakos.de
Website: www.nakos.de

OBJECTIVES AND DEVELOPMENT OF DGBS

The primary objective of our work is to provide support to people who are affected by bipolar disorder, either directly or as friends and family members. By means of a practical trialogic culture, we aim to promote self-help in particular but also scientific discussion of the symptoms and also to raise the awareness, understanding and acceptance of bipolar disorder in society and in healthcare policies.

1999
- Association founded in the course of the 3rd International Conference on Bipolar Disorder, Pittsburgh/USA

2000
- Launch as trialogic society for professionals, sufferers, friends and family

2001
- website www.dgbs.de
- 1st DGBS Annual Conference in Freiburg im Breisgau

2002
- Internet forum for people with bipolar disorders and their friends and family: www.bipolar-forum.de
- Publication of the first white paper on bipolar disorders in Germany

2003
- Support for development of an electronic patient journal
- start of the DGBS publication series

2004
- Bipolar support network BSNe founded, merging support groups from all over Germany

2005
- Publication of the membership magazine InBalance
- DGBS “Young Scientists” work group founded

2006
- Start of training seminars for doctors in psychiatric institute outpatient departments
- First DGBS film: “The poles of Saturn - living between mania and depression”
- White paper on bipolar disorders in Germany, 2nd revised edition
- 1st seminar for friends and family of people with bipolar disorders

2007
- 1st Bipolar Disorders Health Day on 8 May 20017 at the Französischer Dom, Berlin
- IN BALANCE foundation for bipolar disorders founded by the actress Eleonore Weisgerber
- Presentation of the foundation on the Johannes B. Kerner TV programme on ZDF

2008
- Preparation of guidelines on the diagnosis and treatment of bipolar disorders begins in cooperation with the German Association for Psychiatry, Psychotherapy and Psychosomatics (DGPPN)

2009
- Amendments to Articles of Incorporation: Strengthening of association’s self-help objectives
- Bipolar sufferers‘ self help working group founded
- Outcomes analysis in the context of S3 guidelines on investigating the current care situation for bipolar patients in Germany

2010
- 10th DGBS Annual Conference in Friedrichshafen on Lake Constance
- Expansion of the range of services (e.g. telephone counselling for sufferers and their friends and family, newsletter)

2011
- Relaunch of the membership magazine InBalance
- Website redesign
- Expansion of telephone counselling for sufferers and their friends and family as a result of voluntary contributions

2012
- Online publication of S3 guidelines at www.leitlinie-bipolar.de
- New DGBS patient booklet; funded by the Federal Ministry
- Initial steps towards creating an all-Germany support network at state level as a successor to the BSNe

2013
- Publication of S3 guidelines in book form (Springer Verlag)
- DGBS booklet for general practitioners
- DGBS becomes an Associate Member of the International Society for Bipolar Disorders (ISBD)
- First DGBS Seal of Quality awarded to LWL-Klinik Dortmund
- Family and Friends Work Group founded

2014
- Other exemplary clinics are recognised by DGBS and thus recommended for bipolar sufferers
- DGBS presents its trialogue concept at the ISBD congress in Seoul, South Korea
- DGBS Bipolar Roadshow makes guest appearances in eight German states and raises awareness of the illness with a cultural programme
- Aretäus Prize is awarded for the first time
- Establishment of DGBS Departments as successors to the work groups

2015
- 15th DGBS Annual Conference in Essen
- New design for the Annual Conference: division into two parallel events with many points of intersection
- Launch of the Self-help Learning Centre project: Seminars to train self-help group leaders
- Volunteer support enables the telephone counselling line to be made accessible five days a week from now on
- Contributions on the internet forum pass the 500,000 barrier

2016
- Main office moves to Frankfurt am Main
- Continuation of the seminar series for friends and family and self help participants
- active contribution to the ISBD Congress in Amsterdam

2017
- Update to S3 bipolar disorder guidelines
- Continuation of the Bipolar Roadshow event series

DO YOU KNOW ABOUT...

... our **website www.dgbs.de** , which has the most comprehensive information on bipolar disorders on the German-language internet?

... our **telephone counselling line** we are there for you on **0800 55 33 33 55** five days per week. Detailed times are on our website.

... our **email counselling?** Contact us at **info@dgbs.de**.

... our **seminars for family members?** We run these seminars throughout Germany and they are regularly fully booked Find out about forthcoming seminars on our website.

... our **psychoeducational website www.ratgeber-bipolar.de?** This explains all aspects of the illness for you. Clear, easy to understand and easy to remember.

... our **Internet support forum www.bipolar-forum.de**
Exchange views and experiences with other people with bipolar disorders, family members and others with an interest

... our **membership magazine InBalance?** Also available to non-members for a nominal fee. Just email info@dgbs.de

... our **booklets and flyers?** Our booklet for patients and family members, the DGBS GP booklet, our fundraising brochure and our flyers and information materials are available to buy from our website.

... our **DGBS creative initiative?** Creative bipolar people introduce themselves and present their work on a special section of our website

... our anti-stigma project **Bipolar Roadshow** Find out more at **www.bipolar-roadshow.de**

... our **newsletter**, which will keep you up to date on everything to do with bipolar disorders and DGBS? It's very easy to subscribe on our website **www.dgbs.de**

... our **Self-help Learning Centre project?** These training seminars for the leaders of bipolar support groups take place twice a year. Find out more and get the current dates from our website.

... our **support package for self help groups?** The starter package for newly established bipolar groups and the basic package for existing groups is available to DGBS members for a small fee.

I hereby apply for DGBS membership. As a DGBS member, you will always be kept up to date, receive a free copy of our membership magazine InBalance and pay reduced entry fees to DGBS events And you are supporting our work in relation to the concerns and interests of people with bipolar illness and their family members.

☐ **Become a member** *Annual membership fee*

☐ €60.00 Stabilising Membership Fee
For anyone who believes it's important for the DGBS to continue to be stable, ambitious and independent

☐ € 40.00 Standard Membership Fee

☐ € 20.00 Concessional Membership Fee
For pupils, students and people on low incomes, in receipt of welfare benefits or ALGII [unemployment benefit] on presentation of documentary proof

We of course hope that many members will opt for the Stabilising Membership Fee.
All members are entitled to vote at the Membership Meeting

** required field, please complete*

Title / Name/ Surname *

Clinic / Practice

Street *

Postcode / City / State *

Telephone / Fax

Email *

Optional information: I am ☐ a sufferer ☐ a family member ☐ a professional / care provider ☐ an interested party

Granting a SEPA Direct Debit Mandate:
I hereby authorise the DGBS, Deutsche Gesellschaft für Bipolare Störungen, to collect payments by direct debit from my account referred to below. I also instruct my bank to honour the direct debits by DGBS from my account.
Note: *I can request a refund of the amount debited within a period of eight weeks from the debit date. The conditions agreed with my bank shall apply.*

Account holder

IBAN

BIC

Date

Signature

Please send to: **DGBS, Psychiatric Clinic, Heinrich-Hoffmann-Straße 10, 60528 Frankfurt/M., Germany**

THE CREATIVE SIDE OF BIPOLAR DISORDER

All the works shown in this booklet are by bipolar artists:

Dietmar Rüß ı *55171* (p. 01/02), *65398* (p. 19), *Autumn in Barnstorf Forest* (p. 28), *Groynes at Cape Arcona in Fog* (p. 30), *Morning on the Warnow* (p. 31)

Martin Kolbe ı *Dynamics* (p. 04), *The Cut* (p. 08/09), *Blue Burst* (p.22/23)

Kolja Raic Kohnen ı *Birds at Lake* (p. 06), *Bon appétit* (p. 38/39), *Bridge* (p. 42/43)

Florette Hill ı *Moss* (p. 10/11), *Hold Me Tight* (p. 52)

Franzi Lange ı *Going Under* (p. 12), *Helpless* (p. 13), *Room in the City* (p. 14), *The Forest of Books* (p. 50)

Holger Rudolph ı *Snow Beasts* (p. 16)

Yvonne Lautenschläger ı *Veggie Tango* (p. 18), *curriculum vitae* (p.26), *2 Sisters No. II* (p. 47), *Bubblegum Machine (A)* (p.51), *Veggie Spa* (p. 59)

Ramona Freitag ı *Splash* (p. 20/21), *Escalator Central Station Berlin* (p.32)

Andreas Rosenberger ı *7x7x7 (7)* (p. 36/37)

The DGBS Creative section of our websitewww.dgbs.de has more paintings, drawings and collages by bipolar artists as well as photography, poetry, short stories, music and videos.

Gefördert durch:

Bundesministerium
für Gesundheit

aufgrund eines Beschlusses
des Deutschen Bundestages

DGBS
German Society for
Bipolar Disorders

AN EMOTIONAL ROLLER COASTER – MANIA AND DEPRESSION: BIPOLAR DISORDER

Everyone has moments of sadness, depression and lack of vitality. The transition from such "normal" mood swings to an illness which requires treatment is often fluid. Bipolar disorder, previously known as manic depression, is a condition with an episodic progression that involves extreme mood swings and significantly impairs quality of life.

The aim of this guidebook is to provide easily understandable information about the various manifestations of depression and mania. It explains how to recognise the illness and how it progresses. We discuss the medication and psychotherapy which are used to treat bipolar disorders. This guidebook is intended to provide introductory information for sufferers and their family members. It is published by Deutsche Gesellschaft für Bipolare Störungen (DGBS) e.V. (German Society for Bipolar Disorders), a charitable organisation whose key objectives are to raise awareness of the needs of people with bipolar disorder amongst the public and policy makers and to promote self-help, further training and research.

THE AUTHORS

PD Dr. phil. Rita Bauer Dipl.-Psych., Dipl.-Theol., Psychological psychotherapist (VT), Department of Psychiatry and Psychotherapy at the University Hospital Carl Gustav Carus, Dresden University of Technology

Prof. Dr. med. Dr. rer. nat. Michael Bauer Director, Department of Psychiatry and Psychotherapy at the University Hospital Carl Gustav Carus, Dresden University of Technology, former DGBS Chair

Dr. med. Ulrike Schäfer Specialist in Paediatric Psychiatry, Neurology and Psychiatry, Psychotherapy, Göttingen

Volker Mehlfeld former DGBS Board member representing sufferers of bipolar disorder, Berlin

Martin Kolbe Musician, DGBS Board member representing sufferers of bipolar disorder , Zurich