AKADEMIE FÜR
GANZHEITLICHE MEDIZIN
PSYCHOSOMATIK &
PSYCHOTHERAPIEWISSENSCHAFTEN

Prof. Dr. Andrawis
Favoritenstrasse 37/16
A-1040 Wien
med.pth.praxis@gmail.com

+43 650 744 88 63
+48 516 061 427
andrawis-akademie.com

Bipolar affective disorder ICD10 Chapter V F. F31

The bipolar affective disorder is a psychological disorder characterized by recurrent episodes of disturbance of the mood of those affected. Depression and mania occur alternately. Manic episodes usually begin abruptly and last between 2 weeks and 4-5 months. Depression tends to last longer (about 6 months). Other symptoms that may occur during this phase are usually due to changes in mood and activity. Recurrences are common. The beginning of individual episodes is often associated with stressful events (Dilling H, Mombour W, Schmidt M H, 2011).

Bipolar affective disorder currently minor or moderate depressive episode.

ICD-10 V F31.3

The bipolar disorder differs from depression in the manic phases. Symptoms of a manic episode are: Overactivity, reduced need for sleep, uninhibited behaviour and exaggerated self-assessment. The symptoms of the depressive episode are characterized by mood swings, feelings of guilt, joylessness and listlessness. Like "pure" depression (also called "unipolar depression"), bipolar disorder affects not only mood, but also other areas such as drive, thinking, and biorhythm.

Since a bipolar affective disorder is often not recognized, it usually takes many years from the first episode of the disease to the correct diagnosis. These circumstances increase the number of people affected in Europe from 2.5% to 5%.

The bipolar disorder usually begins before the age of 25 and thus on average more than ten years earlier than depression (also called "unipolar depression"). Men and women are affected about as often. The risk of suffering from a special form of the disease called "rapid

cycling", in which manic and depressive phases alternate very frequently (four or more phases per year), is increased in women. Young people can also suffer from a bipolar affective disorder.

A combination of different factors (e.g. stressful work or family relationship) is assumed to be the trigger for a disease. At the neurological level, this leads to an imbalance in the brain, with the neurotransmitter "noradrenaline" in particular playing a decisive role in the development of the disease.

The manic-depressive disorder often breaks out at an early age, occurs similarly often in different cultures and occurs in families. People who are closely related to persons suffering from bipolar disorder have a tenfold higher risk of developing bipolar affective disorder. If both parents suffer from a bipolar disorder, the risk of developing the disease increases to 50% for their children.

The frequency of the disease episodes and the course of the bipolar disorder vary greatly from person to person (Kasper et.al. 2006).

According to Kasper et. al. (2006), the bipolar affective disorder shows three manifestations, which are distinguished by their mood: The first is called "low phase depression", the second "mania/hypomania", and the third "normal phase", in which neither a manic nor a depressive phase is present. The process is characterized by alternating phases between depression and mani/hypomania. An appearance can also be a mixture of both phases. This progressive form is characterized by an alternation of at least one depressive phase with a subsequent strong high phase (mania) or a mixed form of both phases (ibid.).

The schematic illustration shows the various fault phases

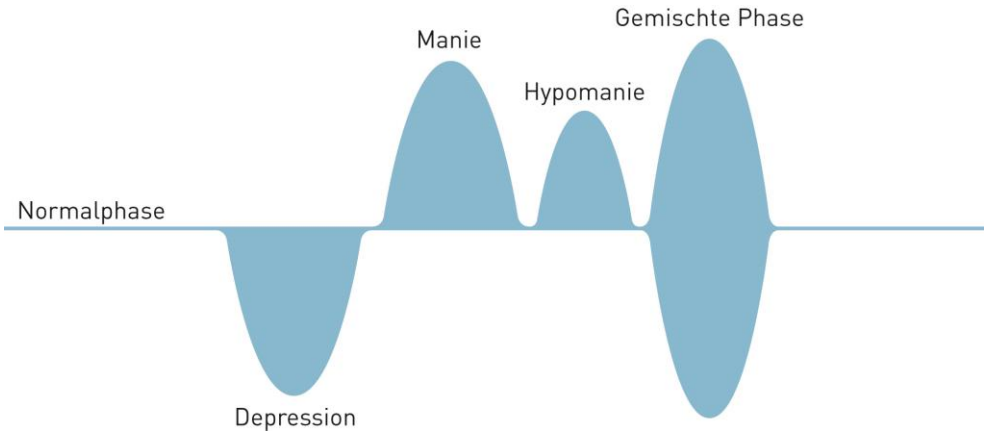

Fig.8: Individual phases of bipolar disorder.

Source: Not modified adopted from (Kasper & Hauk 2006).

Euphoric Phase

If the euphoric phase lasts at least 14 days, this process can be called mania. However, it is not said that the patient had depression before. This is not always the reason for a mania.

Mania

The manic episode is characterized by a mood that is not elevated according to the circumstances. This can vary between carefree cheerfulness and uncontrollable excitement. Those affected are restless, overactive and feel a constant urge to move. They think they have unlimited physical and mental energy and do not feel psychologically ill in any way. Dealing with other people is often without distance, the affected people typically speak a lot, quickly and uninhibitedly. Concentration and attention are impaired, there is an increased ability to distract, often one thought chases the other. It is practically impossible to practise a profession in this state. Those affected, for example, start unrealisable projects or spend a lot of money recklessly. Characteristic for mania is a reduced need for sleep, sexual desire

"libido" can also be increased. Very severe manic episodes can sometimes lead to delusions (e.g. delusions of grandeur or persecution).

Bipolar disease Phase II Mania

he schematic illustration shows the various fault phases.

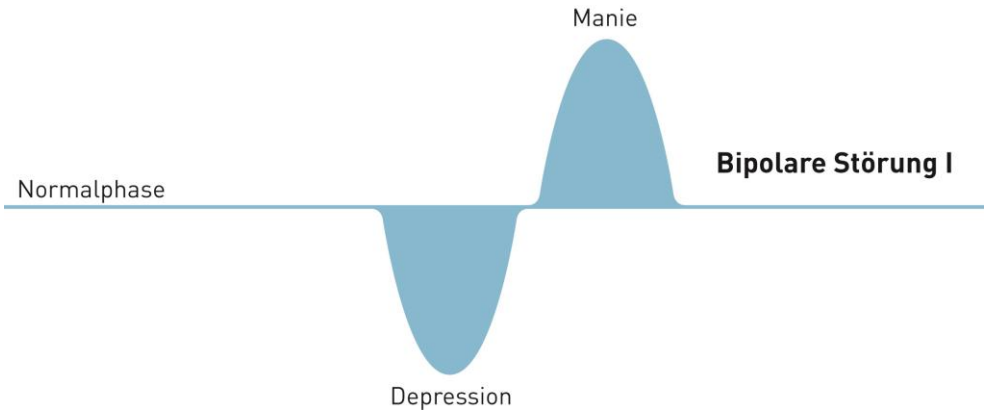

Fig.9: Bipolar disease phase II.

Source: Not modified taken from (Kasper & Hauk 2006).

Hypomania

Hypomania" is a slightly pronounced mania. It usually lasts shorter. The patients are not significantly affected in their lifestyle, i.e. they can usually pursue their profession and do not meet with massive social rejection (Kasper & Hauk 2006).

Bipolar disorder Phase III Hypomania

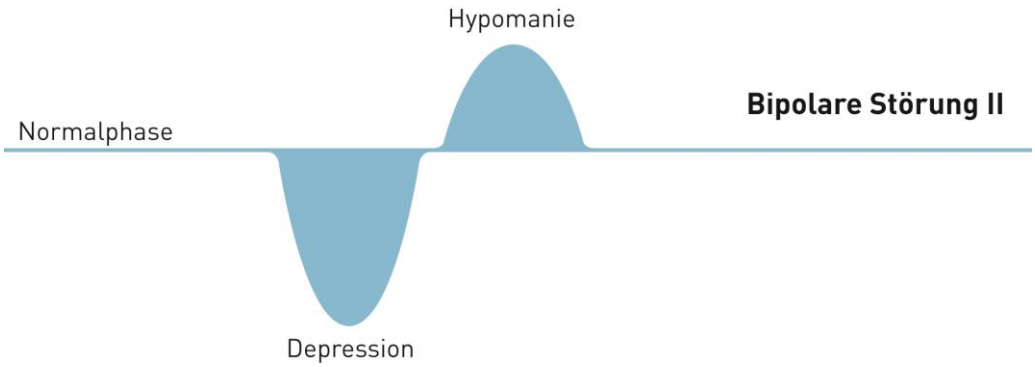

Fig.10: Bipolar disorder phase III.

Source: Not modified taken from (Kasper & Hauk 2006:13).

Even in a hypomaniac episode, those affected usually do not perceive any disease-related changes. On the contrary, they usually feel particularly healthy, vital, attractive, creative, sociable, talkative and efficient. This is precisely why relatives of bipolar people should be particularly attentive and seek medical help at the first sign of elevated mood or increased drive. Because often a hypomania turns into a mania.

Depression in bipolar disorder

In a depressive episode, bipolar patients show the same symptoms as people with a unipolar depression, i.e. depressed mood, lack of drive, joy and interest. Self-reproaches and feelings of guilt can arise, which sometimes refer to the consequences of manic excesses (e.g. loss of friends, debts). Those affected show inhibited facial expressions, gestures and language and withdraw socially. In addition, appetite and sexual activity can decrease. Typical are also sleep disorders with early awakening. Depressive episodes usually last a little longer than manic episodes.

Mixed state

In the so-called mixed affective episode, manic and depressive states usually alternate within hours and may even occur simultaneously (for example, in the sense of aggressively colored depression). In a mixed state, the risk of suicide is particularly high.

Mixed images

This state is similar to the mixed state, but manifests itself in frequently changing phases: at least once a day, often at hourly intervals.

The bipolar affective disorder is classified as follows depending on the frequency, type and severity of the disease episodes:

Bipolar I disorder

In this type of disease, both manic and depressive episodes occur with stable phases in between. The bipolar I disorder corresponds to the classical picture of manic-depressive illness.

Bipolar II disorder

This form is characterized by depressive, hypomania and stable episodes.

Cyclothymia

The so-called cyclothymia represents a special form. In this case, too, mood swings persist, with numerous episodes of mild depression or hypomania, i.e. moderately elevated moods, occurring. However, the individual episodes do not fulfil the full picture of a mania or depression, which is why cyclothymia is not a bipolar affective disorder in the narrower sense.

How is the diagnosis "bipolar affective disorder" made?

It is not easy to diagnose a bipolar affective disorder and it often only succeeds after repeated medical contacts. On average, the diagnosis is only made five to ten years after the onset of the disease. Ultimately, the doctor's experience plays a decisive role in the diagnosis. It is important not only to record the current symptoms, but also to ask those affected and their relatives in detail about their medical history (anamnesis). Structured questionnaires can be helpful.

In particular, previous hypomaniac episodes are difficult to reconstruct because they have a mild and short course compared to mania and are often neither perceived by the patients themselves nor by their environment or classified as disease-worthy. A decisive indication of the possible presence of a bipolar affective disorder is often the fact that close relatives also suffer from bipolar disorder.

At the first occurrence of a depressive episode it is not yet clear whether a unipolar or bipolar affective disorder is present. About a quarter of all people who were diagnosed with "pure", i.e. unipolar, depression at the onset of the disease undergo a manic or hypomanic episode in the course of the following nine years and are therefore classified as bipolar.

As with any mental disorder, bipolar affective disorder must exclude physical causes as possible triggers of symptoms. The consultation with the doctor is therefore usually followed by a physical examination. If necessary, blood samples or X-ray examinations can be ordered.

Changes in mood corresponding to a mania can, for example, be triggered by neurological diseases such as multiple sclerosis or brain tumours or can be caused by hormonal changes (e.g. hyperthyroidism). Manic symptoms can also occur under the influence of certain drugs, such as amphetamines or cocaine.

Therapy

As Andrawis (2018) describes, bipolar disorder requires drug treatment (relapse prophylaxis as long-term therapy), which certainly takes a long time. These measures should be started within one year after the symptoms have subsided. In the event of a relapse, the

therapies are repeated. The episodes can be reduced and lasting freedom from symptoms is achieved (Andrawis A, 2018).

Depression is treated with antidepressants. As Frank (2007) emphasized, psychotherapy is recommended in parallel, but this only makes sense after the acute phase. In the acute episode, an inpatient stay is necessary to ensure intensive therapy and to avert the risk of suicide. In the case of mild forms, outpatient treatment is often sufficient, especially if reliable relatives monitor the patient. The patient himself should not expose himself to any occupational stress - not even road traffic (ibid.).

Once the diagnostic criteria have been met, it is important that internal and neurological examinations begin. As already described by Laux, the blood count is determined in the laboratory (liver, kidneys, electrolytes, blood sugar, cal, thyroid values, vitamin B12 levels, serum iron levels). EEG, CT, possibly NMR, brain scintigraphy, SPECT, rCBF, Doppler sonography follow. A dexamethasone test should be performed if there is a remission of depression. Standardized evaluation scales facilitate the evaluation of the severity of the disease (Laux 2001).

In acute therapy, mood-stabilizing drugs are used, depending on whether the patient is in a depressive or manic episode.

Accompanying measures such as ergotherapy or music therapy can also be helpful.

Prognosis of the bipolar disease

The bipolar affective disorder can have very different courses, which differ greatly in the intensity and frequency of the disease episodes. As a general rule, the duration of the disease-free intervals decreases with each manic or depressive episode. As the disease progresses, its course deteriorates. Therefore, timely diagnosis and adequate treatment are of crucial importance. With the therapies available today, the treatment can be tailored to the individual person and, in favourable cases, can enable him or her to lead a relatively pain-free life.

The problem is that people suffering from a mania usually experience themselves as completely healthy and are very difficult to convince of the opposite. It is often only the partnership, family, social and professional problems caused by mania that cause relatives, friends or colleagues to urge the person concerned to seek medical help. Sometimes complaints that are not related to a mental illness but to a physical illness (e.g. sleep disorders or appetite disorders) lead to a first visit to the doctor.

The consequences of the disease should by no means be underestimated. For example, a woman who has a bipolar disorder for the first time at the age of 25 loses almost 15 years of her unimpaired life if the disease is not treated. It also has an average life expectancy shortened by nine years. Mortality is increased not only because of the significantly higher risk of suicide compared to the general population, but also because of physical diseases, especially of the cardiovascular system. The latter is probably primarily due to the fact that people with bipolar disorder usually experience manic or depressive episodes in every form of depressive disorder.

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Prof. Dr. Andrawis