Bipolar Affective Disorder
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This information is not intended to replace qualified medical or professional advice. For further information about a condition or the treatments mentioned, please consult your health care provider.

Provided the source is acknowledged, the information contained may be freely used.
Introduction

The Mental Health Foundation’s mission is to improve the mental health of all people and communities in New Zealand. Mental health is a positive sense of emotional, psychological and spiritual wellbeing. We define mental health as being the capacity to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face.

People who have information can make informed choices. It is up to each person to decide what mental health is and what it means for them. We believe that providing accurate and helpful information is vital to the process of enabling people to gain control over and enhance their mental health and wellbeing. This includes considering factors that determine our mental health status such as age, gender, ethnicity, income, education, housing, sense of control over life circumstances and access to health services.

The aim of this Mental Health Information New Zealand (MHINZ) project is to provide people with a range of information that can be a starting point for ongoing learning and personal development. It is primarily designed to meet the needs of people working with the discovery that they or those close to them may have a mental health problem sufficiently distressing to warrant medical intervention. This may carry with it some of the stigma associated with mental illness and a loss of personal power in the face of medical labelling and control. So while for some, being given a diagnosis may be a relief, for others it may be upsetting.

We have developed this resource for a range of people including those who have been given a diagnosis, family, whanau, friends and others involved in support and treatment. The information provided is largely from a clinical perspective as it includes psychiatric diagnosis and information on current medical treatment options. We acknowledge that this is one perspective and that different cultures define mental health and wellbeing in a variety of different ways. We invite people to use the resources, references and contacts listed in these booklets to find further information.

Fact sheets summarising information from some of the booklets are available from the foundation’s resource centre or may be downloaded from the foundation's website.

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Bipolar Affective Disorder

Bipolar affective disorder, known also as bipolar disorder and manic depression, is a serious mood disorder. A person with bipolar affective disorder may experience periods of extremely high mood (mania) or times when their mood is very low (depression).

Bipolar affective disorder is more than the temporary feelings of being depressed which we often feel when we are stressed or have problems, or of being high when something goes very well. The essential feature of bipolar affective disorder is that these feelings are sustained, and are associated with a number of other typical symptoms. They also cause difficulty in the person's ability to participate in everyday activities and relationships. Some people may experience a loss of touch with reality (psychosis) during severe episodes of changed mood.

Around one in every 100 people develop bipolar affective disorder. It most often begins between the ages of 15 and 40 and occurs in approximately the same numbers in all ethnic groups. Most people return to their usual level of functioning after periods of illness, although about 20 to 30 percent will have some ongoing difficulties.

Bipolar affective disorder can occur quite quickly. A person who has previously been healthy and coped well with their usual activities and relationships can develop symptoms of a first experience of mania over a number of days or weeks. Occasionally it may occur gradually, with the problems increasing over a number of months or years, leading up to a first period. Sometimes the person will have had previous periods of depression.

There is no chemical test to diagnose bipolar affective disorder. A diagnosis is made when the person has some or all of a set of symptoms. For this reason it is very important for a health professional to get a full understanding of the difficulties a person has had, from both the person and their family whanau or others who know them well, if there are any symptoms of mood disorder.

Before bipolar affective disorder can be diagnosed there must have been symptoms of mania for at least one week. For a person who has previously had depression, bipolar affective disorder is only diagnosed if they have an episode of mania at some point.

Bipolar affective disorder can be effectively treated and people can recover. The earlier treatment is started, the better their chances of recovery.

The symptoms and treatment of depression for someone who has bipolar affective disorder are the same as the symptoms and treatment of depression.

The symptoms of bipolar affective disorder can be of three types:

- symptoms of mania
- symptoms of depression
- mixed symptoms of mania and depression
Symptoms of mania

Most people with mania will not complain of problems. They feel fantastic. It is others around them who see that there is a problem. The symptoms of mania may vary between individuals and, over time, in one individual. Symptoms can be divided into three categories - mood, physical, and cognitive (related to thoughts and beliefs) symptoms. With severe mania there may be symptoms of psychosis (loss of touch with reality).

To diagnose mania, mood symptoms and some or all of the other symptoms must have been present for at least one week. With mania these symptoms seriously disrupt the person's life and relationships. If these symptoms are present, but the person's life is not so seriously affected, then the term used is hypomania ('hypo' meaning 'less than').

Mood symptoms of mania

- **Elevated or high mood** can be infectious, with the person initially seeming like the life and soul of the party. They will describe feeling great or never better. However, their behaviour will be recognised as excessive by those who know them.

- **Irritable mood** may be the main mood change, or may be present for periods, with high mood at other times.

- **Rapidly changing intense emotions** can range from laughter to tears to anger and back. This may sometimes be called labile affect.

Physical symptoms of mania

- **Reduced need for sleep.** People may feel great after only a few hours sleep, or, with severe mania, they may go without sleep for days.

- **Increased energy.** Often people have boundless energy and feel physically great. However they may be unable to stop or rest and this can become uncomfortable.

- **Increased appetites** for food, sex or other forms of pleasure. There is often no regard for the consequences, and they may, when well again, feel embarrassed, ashamed or regret their actions.

- **Increased activity.** People may do many things at once. They may spring clean the house, paint a room and mow the lawn all in a morning. This may mean they get a lot done initially, but as the condition develops what they do becomes more and more disorganised, with many things started but few finished.

- **Loud and fast talk** which may reach the point where it is impossible to interrupt the person.
Cognitive symptoms of mania

- **Racing thoughts.** To an observer, it may seem that the person's talk rapidly jumps from one topic to another.

- **Being easily distracted.** The person's attention jumps from one thing to another, and often they are drawn to unimportant details. For example, they may go from talking about a crack in the wall, to a bird outside, to the sound of music next door.

- **Increased sense of self-importance** may start as increased self-confidence, but soon develops so the person has an unrealistic sense of what they can do. For example, borrowing money and starting a business in a field where they have no experience. If the mania is severe, they may lose touch with reality, believing perhaps, that they have a special relationship with God, or that they have special powers. If people are thought to be exhibiting psychotic symptoms, it is important to confirm that their experiences are outside of what is considered normal or acceptable within their culture.

- **Loss of insight.** The person loses the awareness that their behaviour and experiences are a result of illness. This is a characteristic feature of bipolar affective disorder, particularly in the early stages.

Symptoms of psychosis

Severe mania may cause the person to develop symptoms of psychosis. This usually takes the form of an exaggeration of the cognitive symptoms. Thoughts may race so fast that talk is incomprehensible. Over-activity and easy distraction may result in total disorganisation. The person may have unusual or altered beliefs or hear voices regarding their increased sense of importance or their powers. They may believe that they:

- have a special relationship with or are someone famous such as God, Jesus, the Queen, etc
- can control events in the world
- have a particular destiny, for example, to save the world.

Sometimes these beliefs or voices may take on a more paranoid form. The person believes they are being persecuted, perhaps because of their special powers or status.

Symptoms of depression

Signs of depression may vary between individuals and over time in an individual. Not everyone with depression will complain of sadness or a persistent low mood. They may have other signs of depression such as sleep problems. Others will complain of vague physical symptoms.

Like mania, the symptoms of depression are often divided into three categories - mood, physical, and cognitive (related to thoughts and beliefs). Some people will also have anxiety symptoms. For a diagnosis of depression to be made, mood symptoms and some or all of the other symptoms must have been present for at least two weeks.
Mood symptoms of depression

- **Persistent low, sad or depressed mood.** This can be described in varying ways by people, especially if they are from non-European cultures. The person may describe feeling empty, having no feelings, or may complain of pain.

- **Loss of interest and pleasure in usual activities.** This is a reduced ability for enjoyment. It includes loss of interest in sex.

- **Irritable mood** may be the main mood change, especially in younger people, and in men (especially men from Maori and Pacific peoples).

Physical symptoms of depression

- **Change in sleeping patterns.** The most common change is reduced sleep, with difficulty getting to sleep, disturbed sleep, and/or waking early and being unable to go back to sleep. Some people sleep too much. Most people with depression wake not feeling refreshed by their sleep.

- **Change in appetite.** Most often people do not feel like eating and as a result will have lost weight. Some people have increased appetite, often without pleasure in eating. This is often seen in those who also sleep more.

- **Decreased energy, tiredness and fatigue** which may be so severe that even the smallest task seems too difficult to finish.

- **Physical slowing or agitation** often accompanies severe depression. The person may sit in one place for periods and move, respond and talk very slowly; or they may be unable to sit still, but pace and wring their hands. The same person may experience alternating slowing and agitation.

Cognitive symptoms of depression

- **Thoughts of worthlessness or guilt** involve loss of confidence in self and excessive guilt about past minor wrongs. As a result of feeling bad about themselves, people may withdraw from doing things and from contact with others.

- **Thoughts of hopelessness and death,** when the person may feel there is no hope in life, wish they were dead or have thoughts of suicide.

- **Difficulty thinking clearly.** People may have great difficulty concentrating - they may not be able to read the paper or watch television. They may also have great difficulty making even simple everyday decisions.

Mixed mood symptoms

This is when there is a mixture of symptoms of mania and depression. Mood alternates between high and irritable, and depressed. The person may be unable to sleep; be overactive but feel tired; be agitated, and alternate between feeling hopeless and feeling overconfident.
Course of bipolar affective disorder

The course of bipolar affective disorder is very variable. Most people will have a number of high or low periods over time. In general, they will recover from mania more rapidly than from depression, usually over a number of weeks.

Periods of mania or depression frequently occur one after the other. Most often, depression follows mania. Between times most people return to their everyday level of activities. Some people (around 20 to 30 percent) continue to have low grade symptoms and difficulties in their lives, particularly with relationships and work.

Early access to treatment improves the person's chances of the best possible or full recovery. Many people have long periods of wellness between isolated periods of mania or depression. Some people, unfortunately, have increasing frequency experiences with less recovery time in between. The gap between experiences may decrease with age.

Risks associated with bipolar affective disorder

- **Delays in accessing care.** These may increase the severity of the condition, cause poorer response to treatment, and result in possible long-term unwellness and subsequent disability.

- **Frequency.** There is some evidence that the more often a person experiences mania, the higher their chances of having them still more often. A good relationship with health professionals involved in treatment, continuing treatment where this is advised, education for people with bipolar affective disorder and their families and whanau and clear plans to help them stay well, are critical to lowering this risk.

- **Alcohol and/or drug abuse** is a very common complication of bipolar affective disorder, particularly where it is severe. Early recognition and treatment of co-existing alcohol and drug problems are very important to helping the person make the best possible recovery.

- **Behaviour** during a manic episode may result in damage to relationships, legal problems, and later regrets. Many people with this condition lose important relationships, face conviction charges, and spend long periods attempting to repair the financial and personal damage which has occurred during times of mania. Again, the best possible care can greatly reduce these problems.

- **The risk of suicide** with bipolar affective disorder is significant – the lifetime rate of attempted suicide is 30 to 50 percent. For completed suicide it is about 10 to 15 percent. Risk is highest over age 55, and during depression. The time of greatest risk may be during the initial period of beginning to recover from depression. It is important that any suicidal thoughts or urges are taken very seriously and the person receives the best possible care.

The risk of violent behaviour in people with bipolar affective disorder is little different from that of the wider population. However, during times of illness, particularly of mania or where there are psychotic symptoms, the risk of violence can be significantly increased. This is especially so where people are manic and others try to stop them doing things they wish to do. The risk at these times is further heightened by co-existing alcohol or drug abuse, or having a past history of violent behaviour. Again, prompt and optimal treatment can prevent illness escalating to the point where violence occurs.
Myths about bipolar affective disorder

NOT TRUE  *People who have been manic are maniacs.*

What is true is that mania is an illness from which people recover, and become no different to anyone else

NOT TRUE  *People with bipolar affective disorder are aggressive violent people.*

What is clear is that outside times of acute illness, people with this condition are as safe to others as any other member of the community. With good care and treatment, risk during times of acute illness can be minimised

NOT TRUE  *People with bipolar affective disorder cannot recover and lead full lives.*

In fact, with early and optimal treatment, recovery is the rule not the exception.

Causes of bipolar affective disorder

We do not know the exact cause of bipolar affective disorder. Current theories see it as a diverse condition, possibly reflecting a number of separate underlying causes. Different causes may operate in different people. This may be why there is variation in the way the condition develops, in its symptoms, and in its course. There is clear genetic (inherited) involvement in its cause. If someone in the family whanau has the condition, relatives have an increased risk of developing it. The population risk is one in 100, but if a parent, brother or sister has the condition, the risk is about one or two in ten.

Causes may include changes in the activity of three brain chemical messenger systems – dopamine, noradrenaline and serotonin. What is currently known is that:

- Changes in function in some parts of the brain, shown on brain scans, occur in some people with bipolar when they are unwell.
- Changes in some of the brain chemical messenger systems occur in some people with bipolar affective disorder.
- Stressful life events or circumstances, such as poverty, unemployment, loss of relationships can start periods of illness.
- There are no factors which are seen in all people with bipolar affective disorder.

The stress-vulnerability model suggests that different factors together make a person more vulnerable to bipolar affective disorder. Stress can trigger the illness. If a person is particularly vulnerable, the stress of daily living may be overwhelming and cause high levels of ongoing unwellness. For someone with lower vulnerability, higher levels of stress can be tolerated before the illness is triggered.

People with bipolar affective disorder often believe they developed a mental illness because things have gone wrong in their lives - it could be poverty, abandonment, sexual or physical abuse, being in an unhappy family whanau, feeling alienated from society or not living up to people's expectations. Other people with bipolar affective disorder cannot so easily find things that have gone wrong in their lives. They may agree with the view that their mental illness is genetic or biological in origin. A lot of people with bipolar affective disorder believe it is a combination of these things. Sometimes people think their illness is a punishment for their moral or spiritual failure. It's important to remember that it is not your fault you have a mental illness.
Families and whanau, especially parents, can worry that they caused their relative to develop bipolar affective disorder. Sometimes they feel blamed by mental health professionals which can be very distressing for them. Most families and whanau want the best for their relative. It is important for them to understand what factors have contributed to their relative's problem and to be able to discuss their own feelings about this without feeling guilty or blamed.

**Living with Bipolar Affective Disorder**

**Consumer views**¹

Living through bipolar affective disorder is one of the most overwhelming, frightening, isolating and debilitating experiences a person can have. People in crisis may feel their world has fallen apart, that everything is black, that nothing makes sense or that they are in danger. At times, they may feel overwhelmingly elated and restless. People experiencing bipolar affective disorder often lose hope or the belief that they can recover and lead a worthwhile life. But those of us who have come through episodes of mental illness are able to look back and see how temporary our loss of hope was. Everyone with mental illness can lead a worthwhile life, even if it is not quite the life we had planned for ourselves.

**Discrimination and stigma**

Many people feel ashamed of having bipolar affective disorder and can sense other people's fear, prejudice and low expectations for them. Media coverage can give the wrong impression that people with mental illness are likely to be violent. Employers and landlords frequently don't really want to know people who have a mental health problem. Workmates and friends may turn their backs on a person they know who has mental illness. Even families and whanau and mental health workers can be over-anxious, controlling and pessimistic about lives of people with bipolar affective disorder. None of this helps. Sometimes the discrimination feels worse than the illness itself.

**Support and information**

People with bipolar affective disorder often do better if they seek support people who are caring, non-judgemental and see their potential. Some get their best support from others who have been through the same kind of experience. Other people find a counsellor or another type of mental health worker who is supportive. Their friends and family whanau may offer good support. People with bipolar affective disorder can make more informed choices if they educate themselves about their condition and the types of treatment and support that are available. It is also useful to know about patient rights.

**Using services**

Many people with bipolar affective disorder, sooner or later, go to see their GP or a counsellor or are referred to mental health services. If you fear you might harm or kill

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¹ A consumer is a person who experiences or has experienced mental illness, and who uses or has used mental health services. The term also refers to service user, survivor, patient, resident, and client.
yourself it is vital that you seek help immediately. Sometimes it is hard for people with bipolar affective disorder to seek help because they feel ashamed and want to hide their distress. Acknowledging they have a mental health problem and need help can be very scary. People with bipolar affective disorder often say the best services are ones where they are listened to, treated as equals and are given support or treatment that works for them. Otherwise, the service is unlikely to meet their needs.

Recovery
Sometimes people are given quite pessimistic predictions about their lives by mental health professionals. But even if you continue to have episodes of bipolar affective disorder you can still experience recovery and live a happy and worthwhile life. One person describes recovery like this:

"Recovery is not just about getting rid of symptoms. It is about getting back any lost rights, roles, responsibilities, potential, decisions and support."

"The process of recovering is about beginning to hope or rekindling the hope you once had for a productive present and a rewarding future - and believing that you deserve it! It involves having your own vision of the life you want to lead, seeing and changing old patterns and discovering that symptoms can be managed. It means doing more of what works and less of what doesn't.

"Recovery is about reclaiming your roles as a healthy person, rather than living your life as a sick one. Recovery is about what you want in your life, how to get there and how others can support you in that journey."

Important strategies for recovery
People with bipolar affective disorder have found the following strategies important and useful for their recovery.

- Learn about bipolar disorder and the treatment options for the condition. Get information that helps make sense of what has happened. Health professionals and others involved in assisting recovery should provide information in a way and at a pace that is comfortable for you.
- Take an active part, as far as possible, in decisions about treatment and support. Being involved in decisions is the best way to ensure that you can make informed choices about what is best for you.
- Get treatment and support from people you trust, who expect the best for you and are able to accept how you are now.
- Have the continuing support of family whanau and friends who know about the condition and understand what they can do to support your recovery. Involve family whanau, friends or other important people (such as your church minister or kaumatua) in your treatment if you wish.
- Have the opportunity to recuperate and to ensure that your physical and spiritual needs are met.
- Find the ways of coping that work best for you. These are different for each person, but are a critical first step on the path to recovery.
- Have the opportunity to get support from culturally appropriate support groups, organisations or advocates (trained supporters) or others who have survived the
experience of the condition and its treatment and who can help you to recover and stay well.

- Become familiar with early warning signs of relapse, and be part of developing a plan to maintain wellness. Health professionals involved in your care will assist with this.

- Take steps to improve your general health. Some daily exercise, a healthy diet, plenty of fluids, and relaxation can all be important in aiding recovery and keeping well.

- Try to sleep regular hours. Go to bed and get up at around the same time, and avoid sleeping during the day. Avoid drinks containing caffeine (tea, coffee, cola or smart drinks, etc). Try to avoid worrying about not relaxing. If you can't sleep at night get up after 30 minutes and do something relaxing.

- Avoid or really cut down the use of alcohol and illegal drugs, as these may worsen the condition and increase your chances of relapse.

- Talk to your health professionals if you are considering stopping your treatment and work together with them to find some compromise that will ensure continuing wellness but address your concerns about the treatment.

- Be realistic in what you expect of yourself, especially during an episode. When things seem too hard, take them on one step at a time.

- Do something enjoyable each day, and try to focus on positive thoughts and memories.

**Family whanau views**

Families and whanau often experience real grief, isolation, powerlessness and fear as they witness their loved one struggling with bipolar affective disorder. During a crisis they may find that they cannot understand the person's behaviour or communicate with them any more. Even after a crisis they may find their relative withdrawn or hard to be around. Their feelings for their relative can swing from compassion for their pain, to grief at the loss of the person they once knew to hostility towards their relative for disrupting their lives. Families and whanau often worry that their relative will never get better and may have to revise their expectations for that person. Families and whanau often live through all this without support from their community or from mental health services.

**Discrimination and stigma**

Families and whanau may feel shame or embarrassment if their relative behaves in an unusual way when they are very unwell. They may shut themselves off from their friends and neighbours or feel that these people are avoiding them. Families and whanau hurt when they see their relative being discriminated against or treated unfairly. Families and whanau can also feel discriminated against themselves, especially by some health professionals who exclude them or appear to blame them for their relative's problems.

**Support and information**

Families and whanau often feel drained and stressed and need support to look after themselves as well as their relative with bipolar affective disorder. Their other family whanau relationships can get neglected when the needs of the person with mental illness
have to take priority. There are several ways families and whanau can get support. They can get in touch with other families and whanau who have had similar experiences. Some mental health services provide good support options for families and whanau. Families and whanau need information on the person's condition, their options for treatment and their rights.

**Experience with services**

Families and whanau frequently find that services do not listen to their views about their relative. Professionals may not always give families and whanau any information about their relative, particularly if they are an adult and don't want their family whanau to know the information. Ideally families and whanau who are involved in caring for someone with mental illness need to be able to communicate freely with professionals about their relative. They may also need some professional help to mend any rifts in their relationship with their relative. Open communication between professionals, families and whanau and the person with mental illness means that families and whanau and their relatives are more likely to get the services they need.

**Recovery**

Most, if not all, families and whanau want to help their relative recover. Unfortunately, sometimes the person with mental illness blames their family whanau and does not want them to be involved in their care. Research shows that if families and whanau can share information, skills and support with their relative and the professionals who look after them, the likelihood of recovery is much greater.

**Important strategies to support recovery**

Family, whanau and close friends of people with bipolar affective disorder have found the following strategies important and useful.

- Recognise that you may need your own period of recovery and time to understand what has happened. Many people go through a period of having all sorts of difficult feelings about what has happened to their loved one.
- Learn what you can about the condition, its treatment and what you can do to assist recovery.
- See yourself as part of the treatment team and, in particular, learn about the signs of relapse and, with the help of health professionals, discuss with the person how you can help them stay well.
- Understand the symptoms for what they are. Try not to take them personally or see the person as being difficult.
- Encourage the person to be as responsible as the stage of their condition allows. Often our natural response is to feel protective, and to want to do everything for them. However, for many people with bipolar affective disorder, reclaiming responsibility for themselves is a critical step to recovery.
- Encourage the person to return to their usual activities without pushing or criticising them. Accepting them as they are now and having realistic expectations is very important.
- Take the opportunity to contact a family whanau support, advocacy group or organisation which is culturally appropriate. For many, this is one of the best
ways to learn about how to support recovery, deal with difficulties, and access services when needed.

- If you need to, encourage the person who has been unwell to continue treatment and to avoid alcohol and drug abuse.
- Find ways of getting time out for yourself and feeling okay about this. Caring for a family whanau member with bipolar affective disorder can be stressful. It is important to maintain your own wellbeing.

**Treatment of Bipolar Affective Disorder**

**Summary of treatment options**

Treatment of bipolar affective disorder involves a number of important components, each of which can be tailored to the person's needs and the stage of the condition. While the emphasis is on community care in some cases, a short period of hospital treatment may be needed. The main components of treatment are described here.

**Medication**

The mainstay of this treatment is mood stabilising and antidepressant medication. Other medicines such as tranquillisers or anti-psychotic medications may be used according to individual need and symptoms during the acute phase of the illness or episodes of depression. Finding the right medication can be a matter of trial and error. There is no way to predict which medication will be effective and tolerated (have fewer troublesome side effects) by any one person. If you are prescribed medication, you are entitled to know the names of the medicines; what symptoms they are supposed to treat; how long it will be before they take effect; how long you will have to take them for and what their side effects (short and long-term) are.

If you are pregnant or breast feeding no medication is entirely safe. Before making any decisions about medication during pregnancy or while breastfeeding, talk with your doctor about the potential benefits and problems associated with each particular type of medication.

**Psychosocial treatments**

Psychosocial treatments are non-medical treatments which address the person's thinking, behaviour, relationships and environment, including their culture. They may include psychoeducation a process whereby the person and their family whanau have the opportunity to learn about bipolar affective disorder, and work together to communicate effectively, solve problems and deal with stress.

Psychological therapies (often referred to as therapy or psychotherapy) involve a trained professional who uses clinically researched techniques, usually talking therapies, to assess and help people understand what has happened and to make positive changes in their lives. They may be specific therapies such as cognitive-behavioural therapy (CBT), which largely focuses on overcoming unhelpful beliefs and has been found to be effective in treating depression. Interpersonal Psychotherapy (ITP) is a therapy exploring relationships which has also proved to be effective.

Counselling may include some techniques used in psychological therapies, but is mainly based on supportive listening, practical problem solving and information giving.
Psychosocial rehabilitation involves supporting people to gain or regain the skills necessary to live a normal life and may include case management.

All types of therapy/counselling should be provided to people and their families and whānau in a manner which is respectful of them and with which they feel comfortable and free to ask questions. It should be consistent with and incorporate their cultural beliefs and practices.

**Complementary therapies**

Complementary therapies that enhance the person's life may be used in addition to prescription medicines and psychosocial treatments.

**Treatment during the phases of bipolar affective disorder**

**Acute phase**

Treatment of mania during an acute phase involves use of medicines to treat the specific symptoms, and ensuring sufficient care and support to prevent any risk or behaviour the person may later regret. This may include compulsory assessment and treatment under the Mental Health Act (1992). Medication prescribed will include mood stabilisers and sedatives or tranquillisers. If there are symptoms of psychosis or the mania is severe, antipsychotic drugs may also be prescribed. During this phase, psychoeducation may begin or continue.

**Recovery phase**

The focus of care during the recovery phase places emphasis on prevention of further periods of mania or depression through the use of mood stabilisers, antidepressants and on psychosocial interventions such as psychoeducation and psychotherapy. The general focus is on helping the person to stay well.

**The place of treatment**

The main place of treatment and care for most people with bipolar affective disorder is in the community. This is where people's natural supports are and where recovery occurs. Where possible, the acute phase is treated in the community, as people tend to improve more quickly outside hospital. However, this relies on having sufficient support to ensure the safety of the person and others, and to avoid over-stressing family whānau or others involved in caring for them. Having access to a range of flexible and co-ordinated community services is the critical factor in the success of community based care.

Inpatient or hospital care is reserved for those situations where the level of a person's symptoms is endangering their or others' safety or preventing treatment.

**Medication**

**Mood Stabilising Medication**

Mood stabilising medication acts to return mood to normal during episodes of mood change, to maintain normal mood, and to prevent further episodes. The main medication used to stabilise mood is lithium carbonate (Lithicarb, Priadel), but where this is ineffective, carbamazepine (Tegretol) or sodium valproate (Epilim) may be used, either instead of lithium carbonate, or occasionally in addition to lithium carbonate.
**Lithium carbonate (Lithicarb, Priadel)**

Lithium has a mood stabilising effect and is effective in preventing further episodes in around 60 percent of those who take it regularly. It is not addictive.

Blood tests are needed to ensure the correct dose and once this is established, blood tests are repeated every three to six months. It is important to talk to your doctor if you are considering stopping lithium. Stopping must be done gradually over several months. Sudden stopping may bring on an episode of mania.

If a woman taking lithium plans to get pregnant it is important to reduce and stop the lithium with the help of her doctor. There is a slightly increased risk of birth defects if lithium is taken during the first trimester of pregnancy. Recent studies have shown that the risk of birth defects is lower than previously thought and if necessary lithium can be used, particularly later in pregnancy with appropriate monitoring such as ultrasound scans.

Lithium has a number of immediate and delayed side effects. The immediate side effects can mostly be overcome by adjusting the dose, taking the tablets with food or using a slow release form of the tablet. For more information see the table titled Side Effects of Mood Stabilisers.

**Lithium toxicity**

The difference between the beneficial and toxic levels of lithium is small so it is important to have regular blood tests to check the level of the medication in the blood and adjust to the correct dose. Once this is established, tests are repeated every three to six months to check that the level of lithium remains within the correct range. Toxic levels may occur if the dose is too high, or if someone has a high temperature, is sweating a lot or is dehydrated.

Symptoms of toxicity include:

- worsening of immediate side effects – especially nausea/vomiting, diarrhoea, and bad shaking
- an appearance of being drunk with slurred speech, drowsiness and staggering.

If any of these symptoms occur, drink plenty of fluid and see your doctor urgently.

**Sodium valproate (Epilim), and carbamazepine (Tegretol)**

These are both also used to treat epilepsy, but can be effective either instead of or in addition to lithium carbonate. They are also used where lithium is not tolerated. They are not addictive.

Both carbamazepine and sodium valproate may be associated with a slightly higher risk of birth defects and are generally not prescribed during pregnancy. They have similar side effects which may include drowsiness, nausea or gastric upset. These effects can often be minimised by taking with food and at night, reducing the dose, or taking slow release tablets.

**Toxicity**

As with lithium, these medications have a level which is needed to get the benefit, and above which toxicity may occur. Blood tests to ensure the right level are required every three to six months.
The symptoms of toxicity include:

- worsening of immediate side effects (listed below) – especially nausea/vomiting, diarrhoea, and bad shaking
- an appearance of being drunk with slurred speech, drowsiness and staggering.

If any of these symptoms occur, drink plenty of fluid and see your doctor urgently.

**New mood stabilisers**

It is possible that new medications used for treatment of epilepsy such as lamotrigine, topirimate and gabapentin may prove to be of use as mood stabilisers. These are currently being studied in overseas trials.

**Antidepressants**

These may be used with caution to treat a depressive phase that is not responding to mood stabilising medication alone. It is important to continue taking the mood stabilising medication as well because when someone with bipolar disorder takes antidepressant medication there is a risk of precipitating a manic episode.

The first antidepressant was discovered in the 1950s by accident. It was a new treatment of tuberculosis (TB), and it was noticed that people with both TB and depression became less depressed when they took this drug. The two earliest classes of antidepressants were the tricyclic antidepressant (TCAs) and the monoamine oxidase inhibitors (MAOIs). These medications work by increasing the amounts of noradrenaline and serotonin, two brain chemical messengers which seem to be reduced when a person has depression.

The TCAs also affect other neurotransmitter systems which in some people can cause unwanted side effects such as weight gain, dry mouth, constipation, drowsiness and dizziness. Nevertheless, TCAs can be very effective at treating depression and are still useful for many people. Each TCA has a different pattern of side effects, so when one is not tolerated there is likely to be another that causes less of that side effect. Because of these side effects, it is necessary to start on a low dose and increase slowly over two weeks or more to reach the effective dose (usually about 150mg per day). For more information about side effects see the table at the end of this section.

The MAOIs can interact with some foods and medicines to cause potentially dangerous hypertension and this class of antidepressant is rarely used nowadays. A newer form of this type of antidepressant has been developed which does not have these dangerous side effects. These are the RIMAs (Reversible Inhibitors of Monoamine oxidase A) and the one available in New Zealand is moclobemide (Aurorix). The effective dose of moclobemide is usually reached over two weeks or more.

Over the past decade the Selective Serotonin Re-uptake Inhibitors (SSRI) antidepressants have become available. SSRIs have their effect specifically on serotonin, and can often be started at the usual effective dose from day one, although the antidepressant effect may take some weeks to occur. The SSRIs available in New Zealand are fluoxetine (Prozac, Lovan, Plenzine & Fluox), paroxetine (Aropax) and citalopram (Cipramil). For more information about side effects see the table at the end of this section.

The newest generations of antidepressants target serotonin and noradrenaline neurotransmitter systems with less effect on other neurotransmitter systems, therefore fewer side effects. There are two available - nefazodone (Serzone) and venlafaxine (Effexor). Venlafaxine is not subsidised, and depending on dose, may cost up to $400
per month. Although more expensive, these newer types of medications are equal in effectiveness to the tricyclics and have less troublesome side effects. For a few people the newer antidepressants may work where the older ones have failed.

**Taking antidepressants**

Antidepressants are not addictive. Apart from the risk of the depression recurring, there are usually no withdrawal effects, although if stopped suddenly there may be mild symptoms such as feeling shaky and having trouble sleeping.

The full antidepressant effect of all these groups of medicines is delayed by one to two weeks or more after reaching the effective dose. However, particularly with the tricyclics, levels of other symptoms such as anxiety and agitation may reduce within a few days.

Many women have taken antidepressants, including the newer medications such as fluoxetine, in pregnancy with no obvious problems for their babies. As some of these antidepressants may get into breast milk, bottle feeding may be recommended.

**Benzodiazepines (tranquillisers)**

The common tranquillisers or sedatives are benzodiazepines (the valium type of medicines). Benzodiazepines can be used initially if levels of distress are very high and causing agitation, severe anxiety and sleep problems. They increase the activity of a chemical in the brain called GABA (gamma amino butyric acid) which regulates alertness. This helps to reduce anxiety, induce sleepiness, and makes the muscles relax.

Benzodiazepines work almost immediately and have few side effects. The main side effect of drowsiness or fatigue may be useful during the initial phase of treatment. This usually wears off.

Benzodiazepines are known to be addictive so they are usually only prescribed for short periods such as one to two weeks. Stopping them needs to be done gradually. Stopping suddenly may produce withdrawal symptoms such as anxiety, insomnia, headaches, nausea and dizziness and, if severe, they may induce epileptic seizures. People with epilepsy must be careful as withdrawal can also make seizures more likely.

People taking benzodiazepines need to be aware that they may become too drowsy or relaxed to drive or operate machinery. Muscle relaxation can be a risk for older people whose muscles may be weak and their risk of falling increased. Older people may also become confused. Those with severe breathing problems need to be careful as benzodiazepines can reduce breathing a little. Benzodiazepines are not advised in pregnancy especially near birth, as they can affect the baby and some of them get into breast milk.

Benzodiazepines are safe with almost all other medicines. The effects of alcohol are magnified by them, so this should be avoided. (For more information about benzodiazepines see the medication section of the article on depression).

**Antipsychotics**

These medications are used to treat severe depression or mania where symptoms of psychosis (loss of touch with reality) are present. Where these symptoms are present, mood stabilising medicines are often ineffective. Usually, antipsychotics are prescribed first, and other drugs are introduced once the psychotic symptoms begin to decrease. They can also be used to prevent further episodes, where mood stabilising medicines are not sufficient.
Antipsychotics work by blocking the effect of a brain chemical messenger called dopamine. Overactivity of dopamine is thought to be part of the problem causing psychotic symptoms. Beneficial effects often have gradual onset over one week or more. In low doses, these medicines are also effective in reducing symptoms of anxiety. This effect is usually immediate. Antipsychotics are not addictive.

There is a considerable range of antipsychotic medicines all of which share different side effects, though in low doses many people will have no, or very few, side effects. The traditional (older) antipsychotic drugs are either low-potency or high-potency, according to the size of dose required to give benefit. The low-potency drugs include chlorpromazine (Largactil) and thioridazine (Mellaril). They mainly cause sedation (tiredness), dry mouth, constipation, dizziness, and various sexual function problems.

The high-potency drugs include haloperidol (Serenace), thiothixene (Thixit), and trifluoperazine (Stelazine). They mainly cause muscle side effects such as shaking, muscle spasm, and restlessness. These muscle side effects can be blocked by the use of side effect medications such as benztropine (Cogentin) and procyclidine (Kemadrin). These medicines can also cause a serious delayed side effect called tardive dyskinesia when used long term. This is where involuntary rhythmic movements of muscles, especially around the mouth, such as chewing or lip smacking, occur. Unlike the other side effects these do not stop when the drug is stopped. Your doctor must monitor for early signs of this to prevent it becoming permanent.

In recent times a number of new or atypical antipsychotics which have significant advantages over the older ones have been developed. They also have a dopamine-blocking action (but to a lesser degree), and in addition they act on the serotonin neurotransmitter system. They are more expensive, but generally cause fewer side effects, probably because of the different neurotransmitter systems involved. Some of the atypical antipsychotics may be useful in people with bipolar disorder with psychotic symptoms who experience intolerable side effects with the older antipsychotics.

There are currently four atypical antipsychotics available in New Zealand – clozapine (Clozaril), olanzapine (Zyprexa), quetiapine (Seroquel) and risperidone (Risperdal). (For a further description of antipsychotic medications refer to the medication section of the article on schizophrenia).

**Medicine interactions - antidepressants**

Most psychiatric medicines tend to react with each other when taken in combination. Their sedative effect in particular may make you feel sleepy. Your doctor will, where possible, limit the number of medications prescribed. You should not mix different types of antidepressants unless instructed by your doctor as this could be very dangerous.

The effects of alcohol and many illegal drugs will also be heightened, so they should be avoided. It is important the doctor knows all the medications (including any herbal medicines such as St Johns Wort) you are taking, as some taken together can be dangerous.
Psychosocial treatments

Psychoeducation

Psychoeducation is a process of working with people with bipolar affective disorder, their family whanau or other people important to them to provide everyone with information about the illness, its treatment and how to support the recovery process. Central to this approach is that family whanau, along with the person with bipolar affective disorder, are members of the treatment team. Together they spend time identifying ways of dealing with symptoms, difficult to understand behaviour, and stress.

The early signs which warn that relapse may be developing are identified and an early response plan is developed. There is also a focus on the factors, such as highly charged emotional situations, which can worsen the condition, and how to avoid them. All family whanau members are taught problem solving techniques and how to communicate clearly. There is also focus on the kinds of support that everyone needs, and how to get this.

There are a number of variations in delivery of this kind of service. Some areas focus on working with individual families and whanau, so that specific attention can be paid to the particular issues and ways of doing things in that family whanau.

The integrated family whanau management approach pioneered by Professor Ian Falloon is an example of such an approach which is used in some parts of New Zealand. Another approach is multi-family psychoeducation groups which have the benefit of expanding the support network to include other families and whanau.

Each approach probably suits some families and whanau better than others, so the ideal is to have the option of all approaches. The reality is that despite good evidence for the cost-effectiveness of these approaches, their use is not yet widespread.

Psychological therapies and counselling

Psychological therapies have been found to be effective in the treatment of bipolar affective disorder, especially for the treatment of depressive symptoms. Often they will be recommended in addition to medication. Therapy may be held on a one to one basis, include partners or families and whanau for some sessions, or be held in a group.

The focus of psychotherapy or counselling in the treatment of depression is on education and support for the person to understand what is happening to them, to learn coping strategies and to pursue a path of recovery. Through these processes people can regain the confidence and belief in themselves that is critical to recovery. Specific therapeutic approaches can then be used within this supportive setting.

Two therapies, cognitive-behavioural therapy (CBT) and interpersonal psychotherapy (IPT), have been clinically researched and found to be effective in the treatment of depression.

Such treatment may be available free of charge at a community mental health service. At a number of community service agencies charges are based on your ability to pay. Private therapists may charge from $60 to $200 per session, but many also have a sliding scale of fees.
**Cognitive-behavioural therapy (CBT)**

The basic theory of cognitive-behavioural therapy is that our thoughts and beliefs influence our feelings and behaviour. The focus of treatment is on identifying specific negative thoughts and actions, and developing ways to change these. A person may become aware that they have automatic negative thoughts. The cognitive part of the therapy helps them to identify and challenge these thoughts. The person may, for example, say that they are always sad. With encouragement from the therapist they may come to see that only certain situations make them sad, and at other times they may experience pleasure. The therapist may encourage them to develop behavioural strategies to help lift their mood, such as going for a short walk or doing some small thing which they may once have enjoyed. These activities are often in the form of homework tasks. CBT also incorporates other techniques such as teaching the person relaxation skills, stress management and problem solving.

CBT alone is effective in all but severe depression, but people with severe depression may also benefit from this treatment as they recover. The benefits of CBT may protect people against future episodes of depression. Treatment is usually time limited and may include eight to 12 sessions over three to six months.

**Interpersonal therapy (IPT)**

This therapy is based on the theory that depression may be triggered by difficulties in the person's relationships with others. These difficulties are often increased when a person is depressed so IPT aims to identify the interpersonal difficulties very clearly. Typical problems can include conflict in relationships, changes in roles and relationships (for example, a woman giving up work and becoming a mother after the birth of a child), grief after loss of a relationship or social isolation. The therapist spends time working with the person to develop ways to overcome their difficulties, and to find ways of relating to others which work better for the person. People may be taught specific techniques such as effective communication skills, assertiveness, and problem solving.

ITP is a time limited, focused treatment which may include up to 16 sessions. Research studies have found it to be effective in the treatment of depression.

**Psychosocial rehabilitation**

This approach has been developed over many years, and is fundamental to providing community care to people with serious mental health problems such as bipolar affective disorder. The basic ideas are a belief in the capabilities of people with the condition, working with them to identify lifestyle goals and helping them to develop the skills necessary to reach these goals.

**Case management** involves active follow-up and co-ordination of the care and treatment needed by a person. Assisting people in finding and maintaining housing and paid employment are an important longer-term goal of this approach, which focuses on assessing the person's needs, and supporting them in their choice as much as possible. It helps them make and maintain their important social supports and helps others to understand and support them. Skill-building programmes, which are often provided in a group setting, may be part of this approach. Examples include:

**Relaxation training**, learning techniques of physical and mental relaxation to help counter the effects of stress.
**Stress management training**, learning ways of managing stressful situations so as to minimise any adverse effects of stress.

**Social skills training**, learning specific skills for relating to other people in social situations, and gaining confidence in such situations.

**Communication skills training**, learning to communicate in a clear and concise way and ensure that the listener has understood what was intended.

**Assertion training**, learning techniques for asserting one's views and needs in a way which is acceptable to and respectful of others.

**Occupational and leisure training**, learning new occupational skills and managing time to maximise the person's occupational function and interests.

While psychosocial rehabilitation approaches alone are not effective in treating bipolar affective disorder they are an extremely important aspect of helping people recover.
Side Effects of Medication

Mood stabilisers - lithium

<table>
<thead>
<tr>
<th>Generic name</th>
<th>Trade name</th>
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<tbody>
<tr>
<td>Lithium carbonate</td>
<td>Lithicarb</td>
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<td>&quot;</td>
<td>Priadel</td>
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</table>

**Immediate side effects**

- **Nausea**: usually lessens over the first weeks of taking it
- **Shaking**: This is like a trembling of the hands
- **Diarrhoea**: If this occurs it is important to drink plenty of fluids
- **Thirst & frequent urination**
- **Blurred vision**
- **Dizziness**
- **Drowsiness or slowing of thinking**

**Delayed side effects**

- **Weight gain**: People taking Lithium may gain an average of three to four kilos. Exercise and a healthy diet help
- **Thyroid gland problems**: In some people who are prone to thyroid problems, lithium carbonate may reduce the level of thyroid hormone. This is checked for by blood tests. If it is found to be a problem the treatment is thyroid hormone tablets, or changing to another medication
- **Kidney problems**: Seem to occur in people who are prone to kidney problems. This is checked with the regular blood test to ensure it is picked up early. If kidney problems occur it is likely that the medication will be changed
- **Skin problems**: These can be either a rash, or acne. If they occur, talk to your doctor.
### Mood stabilisers, continued

<table>
<thead>
<tr>
<th>Generic name</th>
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<tbody>
<tr>
<td>Sodium valproate</td>
<td>Epilim</td>
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<tr>
<td>Carbamazepine</td>
<td>Tegretol</td>
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#### Immediate side effects
- **Drowsiness** (especially from carbamazepine) can be minimised by a slow increase in dose, and taking the tablets at night.
- **Nausea** usually passes over the first weeks. **Vomiting** is unusual and if it occurs see your doctor.
- **Diarrhoea**. If this occurs, drink plenty of fluids.
- **Constipation** (especially carbamazepine) can be minimised by plenty of fluids and eating fruit/vegetables.
- **Dizziness**
- **Shaking** is rare with both of these medications.
- **Headache**. This usually passes over the first days/weeks.

#### Delayed side effects
- **Weight gain** (especially sodium valproate) can be minimised by exercise and a healthy diet.
- **Reduced appetite, weight loss**. Eating small frequent meals helps.
- **Liver irritation**. The regular blood test is used to check for this. If it occurs it may mean changing medications.
- **Rash**. This is rare but is a sign of allergic reaction to the drug. See your doctor immediately.
- **Hair loss** (sodium valproate only) is rare, and involves thinning or patchy loss of hair.
- **Reduced production of blood cells** (carbamazepine only) is rare, but can be serious. If you take this medicine and develop fever, or sore throat, see your doctor immediately. Regular blood tests are used to pick this up early, before serious problems occur.
## Antidepressant medications - tricyclics

<table>
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<td>Amitriptyline</td>
<td>Amitrip</td>
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<td>Tryptanol</td>
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<td>Amoxapine</td>
<td>Asendin</td>
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<td>Clomipramine</td>
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<td>Dothiepin</td>
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<td>Desipramine</td>
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<td>Norpress</td>
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<td>Trimipramine</td>
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### Common side effects of tricyclic antidepressants

- **Drowsiness and loss of energy.** This can be useful if sleep is a problem. In this case the medicine is taken at night
- **Dizziness** especially with standing up from lying or sitting. Care is needed especially in older people as this can lead to falls
- **Dry mouth.** Water and sugar-free gum are good ways to reduce this
- **Constipation.** Plenty of liquids, fruit and vegetables can reduce this
- **Blurred vision.** This may mean reduction or change of drug
- **Trouble urinating.** This is mainly a problem for older men
- **Increased sweating.** While many people notice this most are not troubled by it
- **Weight gain.** Exercise and a healthy diet are the best ways to minimise this
- **Sexual problems** such as impotence, reduced sex drive, or lack of orgasm

### Serious side effects of tricyclic antidepressants

- **Heart problems.** This is only in people who already have heart problems, or are elderly. Some of this group of medications are actually safer for people with heart problems
- **Psychosis** symptoms, or worsening of symptoms of psychosis. This is rare
- **Overdose.** These drugs are very dangerous in overdose, due to their effects on the heart
### Antidepressant medications - RIMAs

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<tr>
<td>Moclobemide</td>
<td>Aurorix</td>
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#### Common side effects of RIMAs
- **Diarrhoea**
- **Anxiety or jittery feeling**, while not common, this can be distressing. It tends to reduce with time, but may mean a change of medicine is needed.
- **Headache**
- **Insomnia**, especially if the medication is taken at night.

### Benzodiazepines

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<tr>
<td>Diazepam</td>
<td>Valium</td>
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<td>ProPam Tab</td>
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<td>&quot;</td>
<td>Stesolid Rectal Tube</td>
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<td>Diazemuls injection</td>
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<td>Clonazepam</td>
<td>Rivotril</td>
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<td>Lorazepam</td>
<td>Ativan, Lorapam</td>
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<tr>
<td>Alprazolam</td>
<td>Xanax</td>
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#### Common side effects of benzodiazepines
- **Drowsiness** is particularly dangerous for people who operate machinery or while driving vehicles.
- **Muscle relaxation** can be a risk for older people whose muscles may be weak and thereby increase their risk of falling.
- **Confusion**, particularly with older people.
- **Breathing difficulties**. Benzodiazepines can reduce breathing a little. Those people with severe breathing problems need to be careful.
- **Dependency** and withdrawal problems - see discussion on previous page.
### Antidepressants - SSRIs

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<td>Fluoxetine</td>
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<td>Plinzene</td>
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<td>Fluox</td>
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<td>Paroxetine</td>
<td>Aropax</td>
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<tr>
<td>Citalopram</td>
<td>Cipramil</td>
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**Common side effects of SSRIs**
- **Nausea.** Sometimes this can be reduced by taking the medication with food
- **Headache.** Sometimes this is an initial effect which wears off
- **Sleep difficulties.** SSRIs may aggravate the sleep problems of depression, though as the medicine works sleep will improve
- **Agitation (feeling jittery).** While not common, this can be distressing. It tends to reduce with time, but may mean a change of medicine is needed
- **Sexual problems** are the most common side effect and affect up to 20 percent of people
- **Weight loss** for some people
- **Rash.** This is not common, but means the medication should be stopped

### Antidepressants - SSRI-like drugs

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<tr>
<td>Nefazadone</td>
<td>Serzone</td>
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<td>Venlafaxine</td>
<td>Effexor</td>
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**Common side effects of SSRI-like drugs**
- **Nausea, headache and dry mouth** may wear off after initial effect.
- **Light-headedness** or dizziness may occur.
- **Blurred or double vision** can be a problem.
- **Sexual problems** are usually less frequent than with the SSRIs.
- **Sleep trouble and abnormal dreams.** If persistent, may require medication to be changed.
- **Sedation and tiredness** may be experienced by others.
- **Weight loss** may occur in some people.
- **Sweating** is occasionally noticed but not usually a problem.
Complementary Therapies

Health, healing and healing practices are varied and differ according to how people view illness. Any health-related practice that increases an individual’s sense of wellbeing or wellness is likely to be of benefit. Talking things over with people you feel comfortable with can be useful and may help to define a problem and ways to begin to tackle it.

The term complementary therapy is generally used to indicate therapies and treatments which differ from conventional western medicine and which may be used to complement, support or sometimes replace it. There is an ever-growing awareness that it is vital to treat the whole person and assist them to find ways to address the causes of mental health problems rather than merely alleviating the symptoms. This is often referred to as an holistic approach. Complementary therapies often support an holistic approach and are seen as a way to address physical, nutritional, environmental, emotional, social, spiritual and lifestyle needs.

Many cultures have their own treatment and care practices which many people find helpful and which can often provide additional benefits to health and wellbeing. Rongoa Maori is the indigenous health and healing practice of New Zealand. Tohunga Punan Ora is a traditional healing practitioner. Traditional healing for many Pacific Islands' people involves massage, herbal remedies and spiritual healers.

In general, meditation, hypnotherapy, yoga, exercise, relaxation, massage, mirimiri and aromatherapy have all been shown to have some effect in alleviating mental distress. Complementary therapies can include using a number of herbal and other medicinal preparations to treat particular conditions. It is recommended that care is taken as prescription medicines, herbal and medicinal preparations can interact with each other.

When considering taking any supplement, herbal or medicinal preparation we recommend that you consult a doctor to make sure it is safe and will not harm your health.

Women who may be pregnant or breastfeeding are advised to take extra care and to consult a doctor about any supplements, herbal or medicinal preparations they are considering using, to make sure they are safe and that they will not harm their own or their baby's health.

For more information see the MHINZ booklet *Complementary Therapies in Mental Health.*
Legislation

New Zealand has laws with specific implications for people who experience mental illness. The following information is a brief introduction to some of these Acts, and gives details on where to get specific information or assistance.

More information may be obtained from the local Community Law Centre or Citizen’s Advice Bureau – look in a telephone directory for details. The local library is a useful place to obtain information or books and resources on the law. Copies of New Zealand legislation are available from government bookshops and can be seen at most public libraries, or on the internet at www.rangi.knowledge-basket.co.nz/gpacts/actlists.html

Recommended publication


Government agencies can provide advice, information and publications in relation to mental health and the law.

**Ministry of Health**
133 Molesworth Street
PO Box 5013
WELLINGTON
Ph 04 496 2000
Fax 04 496 2340
Email EmailMOH@moh.govt.nz
Web www.moh.govt.nz

**Mental Health Commission**
PO Box 12479
Thorndon
WELLINGTON
Ph 04 474 8900
Fax 04 474 8901
Email info@mhc.govt.nz
Web www.mhc.govt.nz

**Department for Courts**
PO Box 2750
WELLINGTON
Ph 04 918 8800
Fax 04 918 8820
Email family@courts.govt.nz
Web www.courts.govt.nz/family

More contact details for government agencies are listed in the following sections.
The Health and Disability Commissioner Act 1994

This Act governs all actions taken by the Health and Disability Commissioner, the office and advocacy services. It is the legal document which gives the authority to ensure the rights are delivered. The purpose of the Act is

"To promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights" (Section 6).

The Act’s objective is achieved through

- the implementation of a Code of Rights (see below)
- a complaints process to ensure enforcement of those rights, and
- ongoing education of providers and consumers.

Code of Health and Disability Services Consumers’ Rights

There are ten rights set out in the code and these rights apply to all health and disability support services in New Zealand, both public and private services. The code gives rights to all people who use health and disability services and describes the obligations of all providers of health and disability services. The Health and Disability Commissioner contracts advocates in each region to ensure the code is upheld.

To make a complaint to the advocate in your region, contact the office of the Health and Disability Commissioner.

The Health and Disability Commissioner

Freephone 0800 11 22 33
E-mail hdc@hdc.org.nz
Web www.hdc.org.nz

AUCKLAND
Level 10, Tower Centre
45 Queen Street
PO Box 1791
Auckland
Ph 09 373 1060
Fax 09 373 1061

WELLINGTON
Level 13, Vogel Building
Aitken Street
PO Box 12 299
Wellington
Ph 04 494 7900
Fax 04 494 7901
The Human Rights Act 1993

Discrimination on the basis of disability is illegal under the Human Rights Act. If you feel you have been discriminated against you can make a complaint to the Human Rights Commission.

Human Rights Commissioner
Freephone 0800 496 877
TTY (teletypewriter) access number 0800 150 111
Email infoline@hrc.co.nz
Web www.hrc.co.nz

AUCKLAND
4th Floor, Tower Centre
Corner Queen & Custom Streets
PO Box 6751, Wellesley Street
Auckland
Ph 09 309 0874
Fax 09 377 3593

WELLINGTON
Level 8, Vogel Building
8 Aitken Street
PO Box 12411, Thorndon
Wellington
Ph 04 473 9981
Fax 04 471 0858

CHRISTCHURCH
7th Floor, State Insurance Building
116 Worcester Street
PO Box 1578
Christchurch
Ph 03 379 2015
Fax 03 379 2019
The Privacy Act 1993

The Privacy Act sets out general rules about the protection of our personal information. Extra rules have been developed to protect health information. These rules are set out in the Health Information Privacy Code, which is contained within the Privacy Act.

The Health Information Privacy Code sets out 12 rules that agencies must follow when dealing with health information. These rules cover the collection, storage, use and disclosure of health information, and give you the right to access and correct your health information.

The code applies to you whether you are receiving health services voluntarily or under the Mental Health Act.

Under the code, health services can develop their own policies for dealing with health information. You are advised to ask for a copy of their policies. Health services must appoint a Privacy Officer, so find out who that person is in the service you are dealing with. You may request information from or make a complaint to the service’s Privacy Officer.

The Privacy Commissioner.
Freephone 0800 803 909

Office of the Privacy Commissioner
PO Box 466
AUCKLAND
Ph 09 302 8655
Email privacy@iprolink.co.nz (Auckland)
   privacy@actrix.gen.nz (Wellington)
Web www.privacy.org.nz

Further information


The Mental Health (Compulsory Assessment and Treatment) Act 1992

For a person to be compulsorily assessed and treated it must first be determined that they have a mental disorder. The definition of ‘mental disorder’ is described in the Act.

The Act sets out clear procedures that must be followed when a person is compulsorily assessed and treated. People under the Act lose their right to choose and consent to assessment and treatment. All other rights as described in the Health and Disability Commission’s Code of Rights remain.

To ensure a person’s rights are upheld and correct procedures are followed the Minister of Health appoints District Inspectors for each area. They are lawyers and you may request information from or make a complaint to them. You can find out who the District Inspector for your area is by contacting the Ministry of Health or your local community law centre. (Contact details are at the front of this section)

In general, the Act gives young people (16-19 years) the same rights as adults. For people under 16 there are additional protections.

The Ministry of Health publishes helpful user information guidelines on the Mental Health Act. Contact details for the Ministry are at the front of this section.

Further information

The Mental Health Act: Information for Families and Whanau, Schizophrenia Fellowship.

The Schizophrenia Fellowship (SF)
Freephone 0800 500 363

National Office
PO Box 593
Christchurch
Ph 03 366 1909
Fax 03 379 2322
Web www.sfnat.org.nz
Email office@sfnat.org.nz

Look in your telephone directory for the local Schizophrenia Fellowship.
The Children, Young Persons and Their Families Act 1989

This Act applies in two situations.

- When it is decided that children and young people are defined as needing care or protection and,
- where children or young people offend against the law.

This Act defines a child as someone under the age of 14, and a young person as someone who is 14 or over but under 17 years of age. If concerns have been raised about a child or young person’s care or protection in the first instance, an informal meeting is usually called with the family and a social worker.

Formal options available through this Act are:

- family group conference
- application to the Family Court
- removal of the child or young person.

Care and protection issues may mean the involvement of the Child Youth and Family Service (CYFS). Look in your telephone directory under Government Agencies for contact details for your local CYFS.

For more information, it may be helpful to contact:

The Office of the Commissioner for Children
PO Box 5610
WELLINGTON

Ph 04 471 1410
Fax 04 471 1418
Email children@occ.org.nz
Web www.orc.org.nz

Youthlaw Tino Rangatiratanga Taitamariki
Provides free, confidential legal information and advocacy for young people under 25, anywhere in Aotearoa New Zealand.

PO Box 7657
Wellesley Street
AUCKLAND

Ph 09 309 6967
Fax 09 307 5243
Email youthlaw@ihug.co.nz
Web www.youthlaw.co.nz
The Criminal Justice Act 1985

This Act sets out rules that apply to people who have been charged with, or found guilty of committing some kind of criminal act.

One part of the Act applies to situations where a person is experiencing a mental illness AND has been charged with or found guilty of committing some kind of criminal act. A person in this situation can become a ‘special patient’ under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

The Protection of Personal Property Rights Act 1988

This Act describes what can happen legally when a person is unable to make all or some of their own decisions about their personal and property matters. This is called a lack of capacity. The Family Court decides if a person lacks capacity.

In some cases, the Family Court may appoint a welfare guardian for someone who is unable to make these decisions. A welfare guardian has the power to make a wide range of decisions, such as where a person lives and how they should be cared for. A welfare guardian can act and consent to treatment on that person’s behalf.

Family Court contact details are listed at the front of this section.
Further Information

Organisations and groups

Balance - New Zealand Manic Depressive / Bipolar Network

National Co ordinator
PO Box 13266
CHRISTCHURCH
Ph 03 365 8238
Web www.balance.org.nz
Email bipolar@balance.org.nz

Bipolar / Manic Depression Society Inc
Community service that supports people with manic depression / bipolar disorder and their families and carers. Provides pamphlets, booklets, and contact details for support groups throughout New Zealand. Also runs educational courses, support groups, and employs a fieldworker who works with individuals / groups in Christchurch.

CHRISTCHURCH.
PO Box 25068
Ph 03 366 5815
Fax 03 365 5345
Email bipolar.md@xtra.co.nz

Schizophrenia Fellowship NZ Inc. (SF)
SF is a national organisation with branches throughout New Zealand. It provides support, information and education for families and individuals affected by mental illness.

CHRISTCHURCH
P O Box 593
Freephone 0800 500 363
Ph 03 366 1909
Fax 03 379 2322
Email office@sfnat.org.nz
Web www.sfnat.org.nz

GROW
Mutual help mental health movement provides support to people with mental health problems. Friendship is the special key to mental health. Groups meet weekly and are open to all. Consumers run a 12 step programme of self- help / mutual help.

AUCKLAND
Ph 09 846 6869
Email national@grow.org.nz

CHRISTCHURCH
Ph 03 366 5890

DUNEDIN
Ph 03 477 2871
Email growdunedin@actrix.co.nz
Websites
The Mental Health Foundation's website has information about the mental health sector and mental health promotion, news of upcoming conferences both here and overseas, links to other sites of interest and the Foundation's on-line bookstore. It also contains the full text of all the MHINZ booklets which can be downloaded as pdf or Word files.
www.mentalhealth.org.nz

Child and Adolescent Bipolar Foundation
www.bpkids.org

Pendulum Resources. Bipolar Disorders Portal
www.pendulum.org

National Depressive and Manic Depressive Association
www.ndmda.org

Mood Disorders Association (SA) Inc

Books


Bipolar Puzzle Solution: a Mental Health Client’s Perspective by B L Court & G E Nelson. Taylor & Francis, 1996,


The Mental Health Foundation Resource and Information Centre is at the Foundation's Auckland offices and is open to the public. Information and resources are available in a range of formats including pamphlets, books, journals videos, research papers and directories. Anyone living in Auckland may borrow books and videos are lent throughout New Zealand. The extensive collection includes resources on

- Mental Health
- Mental Illness
- Mental Health Services
- Depression
- Discrimination
- Workplace Wellbeing
- Stress
- Maori Mental Health
- Support Groups
- Recovery
- Relaxation
- Self-Help
- Older People’s Mental Health
- Young People’s Mental Health

The centre is open Monday to Friday, 9am to 4.30pm.

Mental Health Foundation of New Zealand
PO Box 10051
Dominion Road
Auckland

81 New North Road
Eden Terrace
Auckland

Ph 0064 9 300 7010
Fax 0064 9 300 7020
Email resource@mentalhealth.org.nz
Web www.mentalhealth.org.nz

**Titles in the MHINZ series of booklets**

Attention Deficit / Hyperactivity Disorder  Dementia
Alcohol Problems  Depression
Anorexia Nervosa  Depression in Children and Young Adults
Attachment Disorder  Obsessive-Compulsive Disorder
Autism  Panic Disorder
Bipolar Affective Disorder  Personality Disorders
Brief Psychotic Disorder  Phobias
Bulimia Nervosa  Postnatal Depression & Psychosis
Cannabis Problems  Problems with Tranquilliser Use
Conduct Disorders  Schizophrenia
Complementary Therapies in Mental Health  Separation Anxiety Disorder
                                    Solvent and Inhalant Problems
| Delusional Disorders | Tourette Disorder |