Bulimia Nervosa

Acknowledgements

The information that has been developed for Mental Health Information New Zealand (MHINZ) has occurred thanks to the significant contributions made by clinicians, consumers and families. Some of these participants include:

*Dr Peter **Adams***
*Dr Nick **Argyle***
*Jo **Beck***
*Lorraine **Burns***
*Joanne **Chiplin***
*Dr Hugh **Clarkson***
*David **Codyre***
*Kate **Cosgriff***
*Assoc. Prof. John **Coverdale***
*Dell **Coyte***
*Dr Sue **Crengle***
*Annie **Cripps***
*Diane **Davidson***
*Rodney **Davis***
*Sandra **Duncan***
*Fuimaono Karl Pulotu **Endemann***
*Mali **Erick***
*Katherine **Findlay***
*Jade **Furness***
*Ani **Goslyn***
*Chris **Harris***
Health & Disability Commissioner
*Carmen **Hodgson***
*Marie **Hull-Brown***
*Beryl **Jane***
*Virginia **Lau***
*Shelley **Mack***
*Dr Hylton Greig **McCormack***
*Ian **MacEwan***
*Dr Peter **McGeorge***
*Dr Jan **McKenzie***
*Dr Pam **Melding***
*Jennie **Michel***
*Sharon **Milgrew***
*Dr Brandon **Nementzik***
*James **Nichol***
*Assoc. Prof Mark **Oakley-Browne***
*Mary **O'Hagan***
*Maureen **O'Hara***
*Dr Tina **Paige***
*Steven G **Patterson***
*Janet **Peters***
*Dr Chris **Perkins***
*Julie **Purdy***
*Sue **Robertson***
Schizophrenia Fellowship
*Dr Rob **Shieff***
*Dr Sandy **Simpson***
*Kenneth **Smedley***
*Suzy **Stevens***
*Lorene **Stewart***
*Alison **Taylor***
*Cindi **Wallace***
*Prof. John **Werry***
*Rick **Williment***
*Monique **Wilson***

Disclaimer

While great care has been taken in the preparation of this text, the Mental Health Foundation cannot accept any legal responsibility for errors or omissions or for damages resulting from reliance on the information contained in this document.

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.

ISBN 1-877318-10-8

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.

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

Table of Contents

Bulimia Nervosa

Bulimia nervosa, commonly called bulimia, is an eating disorder. People with bulimia who want to lose weight try not to eat, but after a while they give in to the urge to eat. They will eat a large amount of food all at once. Almost immediately they will feel so worried that they will try to stop weight gain by such things as self-induced vomiting or by taking large amounts of laxatives to help them get rid of the food by having a bowel motion. This behaviour is often called a binge-purge cycle.

Bulimia normally starts with the person - most often, but not exclusively, a young woman, becoming worried about their weight and shape. This often happens around the time that puberty causes the normal changes to the body shape and weight. Dieting may cause a dramatic weight loss - about half of those who begin this process reach a low enough weight to have anorexia nervosa. The person then loses control of the dieting and begins the pattern of bingeing and purging. Weight gradually rises since the bingeing and purging does not usually keep it down. Many people with bulimia have normal weight but some are underweight and may continue to have anorexia as well - and some are overweight.

About half of all cases of bulimia start before the age of 19, and almost all before the age of 45. Ninety percent of people with bulimia are women. Twenty three percent of women report bingeing quite often and 11 percent report purging. In about five percent of women this occurs often enough to be diagnosed as bulimia nervosa.

Outlook

There is no clear information yet on the long-term outlook for those with bulimia. What we know at the moment is that after 10 years about 50 percent of people who have had bulimia are fully recovered; about 20 percent still have ongoing problems with bingeing and purging and 30 percent relapse from time to time. Studies which have been done so far have found that the death rate is three per 1000 people with bulimia, but many of the studies are so short that this figure is probably too low. Suicide can be a cause of death particularly for those people who have an associated depression. It is also known that people with bulimia stand a higher risk of developing depression, anxiety problems or alcohol and drug problems.

Signs of bulimia

Early signs of bulimia include:

- extreme concern about being too fat
- increasing isolation from others
- food disappearing from the house, especially high calorie foods
- spending long periods in the toilet especially immediately after meals, sometimes with the tap running for long periods
- shoplifting food
- swollen cheeks (a little like mumps) caused by swelling of the parotid gland
- excessive tooth decay - vomiting causes damage to tooth enamel
- a callous at the base of the index finger caused by repeatedly using the finger to vomit.

While bulimia does not appear to affect the person's physical health, over a long period there are a number of serious complications which can occur:

- Repeated vomiting can lead to loss of tooth enamel, damage to the gullet and disturbances in body chemistry. At worst, low potassium levels can cause sudden death from cardiac arrest.
- Laxative abuse can lead to loss of normal bowel function which can cause enlargement of the large bowel and chronic constipation. It can also contribute to low potassium levels.
- Periods do not usually stop, but may be irregular.

Risk factors for developing bulimia

There are a number of groups who are at particular risk for developing bulimia:

- those whose career or sport requires them to be thin - dancers, gymnasts, models or body builders
- those who are overweight
- those with a number of different problems including childhood sexual abuse or neglect, drug or alcohol problems and unstable relationships
- people with diabetes
- those with problems of self-esteem and identity.

Causes of bulimia

We do not know what causes bulimia. There is no clear difference between those who get anorexia and those who get bulimia and they are best thought of as different forms of the same condition. Bulimia develops in certain situations.

Social situations. Bulimia has mainly become a problem for the western world in the last few decades. It does not occur in countries in which food is scarce, or in countries where women are not encouraged to be thin. In the west women have been given the message that they need to be thin to be considered beautiful. Since a thin shape is normal and healthy for only a very few women, others must either struggle with feelings of not being good, perfect or self-controlled enough or begin to diet.

Family and whanau situations. Those who develop bulimia have a higher than normal chance of having a close family or whanau member who has an eating disorder, depression, obsessive-compulsive disorder or alcohol problems. This may mean that there is a genetic aspect to bulimia, or that these families and whanau have emotional or other problems which make them more vulnerable to social pressures, or both. There may also be an increased chance of broken families and whanau and/or abuse within the families and whanau.

Individual situations. A number of writers have described emotional difficulties which they believe are common amongst those who have bulimia. Some stress the struggle people with bulimia have to feel in control of their lives. They turn to dieting as something they can feel completely in control of. Others have suggested that bulimia can be related to difficulties in growing up.

People with bulimia often believe they developed it because things have gone wrong in their lives - it could be abandonment, sexual or physical abuse, being in an unhappy

family whanau or not living up to people's expectations. Other people with bulimia may agree with the view that there is genetic or biological aspect to their condition. A lot of people believe it is a combination of these things. Sometimes people think their problem is a punishment for their moral or spiritual failure. It's important to remember that it is not your fault you have bulimia.

Families and whanau, especially parents, can worry that they caused their relative to develop bulimia. 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 has contributed to their relative's problem and to be able to discuss their own feelings about this without feeling guilty or blamed.

Living with Bulimia

Bulimia differs from anorexia in that it is much more able to be concealed. Sometimes people with bulimia say that they have had it for many years without family whanau or partners knowing anything about it.

Generally the person feels very ashamed and disgusted by the vomiting. This leaves them feeling very isolated and vulnerable to depression and despair.

For family whanau bulimia is very puzzling and frustrating. They tend to feel helpless and find it hard to know how much to watch over the person with bulimia and how much to leave them alone. Often they feel lied to and sometimes they are angry about the amount of food that is 'lost'. They may worry that the person with bulimia will die.

Mothers, in particular, often feel guilty, responsible and angry with the child with bulimia for being difficult. Fathers often feel frustrated, closed out and unimportant. Frequently, the parents cannot agree about the seriousness of the problem or what to do. Often one wants to be tougher while the other feels this will only make things worse. Brothers and sisters may feel ignored by parents whose attention is entirely taken up by the person with bulimia.

People with bulimia who are in a sexual relationship often report that the relationship is not satisfactory. Quite commonly, people with bulimia report having a number of unsuccessful relationships. It can be very important for the partner to understand the problem in order to be helpful. It is also important that the partner participates in dealing with the problem. This can be just as stressful for the partner who will need to make sure that they get plenty of support from family whanau and friends.

Consumer views[1]

Living through bulimia can be overwhelming, frightening, and isolating. People experiencing bulimia 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 fallible our loss of hope was. Everyone with mental health problems can lead a worthwhile life, even if it is not quite the life we had planned for ourselves.

---

[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.

Discrimination and stigma

Many people feel ashamed of their bulimia and, because they can sense other people's prejudice and low expectations for people with mental health problems, often keep their condition hidden. Workmates and friends don't understand and may turn their backs on a person they know who has a mental health problem. Even families and whanau and mental health workers can be over-anxious, controlling and pessimistic. None of this helps. Sometimes the discrimination feels worse than the illness itself.

Support and information

People with bulimia 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. Or their friends and family whanau may offer good support. People with bulimia can make more informed choices if they educate themselves about their condition and the types of treatment and support that are available. It's also useful to know about your rights.

Using services

A lot of people with bulimia, sooner or later, go to see their GP or a counsellor or are referred to specialist services. If you fear you might harm or kill yourself it is vital that you seek help immediately. Sometimes it is hard for people with bulimia 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 mental health problems 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 some episodes of bulimia 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 bulimia have found the following strategies important and useful for their recovery.

- Learn about bulimia and the treatment options. Take part in deciding which are likely to work best for you.
- Involve whanau/friends or other important people (e.g. kaumatua or church minister) in your treatment team if you wish.
- Avoid or really cut down the use of alcohol and illegal drugs, as these may worsen the condition and increase the chances of relapse.
- Talk to your health professionals if you are considering stopping treatment and work together with them to find some compromise that will ensure continuing wellness, but address your concerns about the treatment.
- Get access to information to help make sense of what has happened, know what to expect, and take as active a part as possible in decisions about your treatment and support.
- Get treatment and support from people you trust, who expect the best for you, and who can accept how you are at anytime.
- Have the continuing support of family whanau and friends, who know about the condition and understand what they can do to support your recovery.
- Have the opportunity to receive support from culturally appropriate support groups or organisations who can help you to recover and stay well.

Family whanau views

Families and whanau often experience real grief, isolation, powerlessness and fear as they witness their loved one struggling with bulimia. They may find that they cannot understand the person's feelings or behaviour. They may find their relative secretive, 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 at their relative's bingeing and vomiting. They 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 bulimia. Their other family whanau relationships can get neglected when the needs of the person with bulimia 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 health problems 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 the mental health problem 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 bulimia blames their family whanau and does not want them to be involved in their care. 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 have found the following strategies important and useful.

- Learn about the disorder, its treatment, and what you can do to assist recovery.
- Understand the symptoms for what they are. Try not take them personally or see the person as being difficult.
- Encourage the person 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 member with bulimia can be stressful. It is important to maintain your own wellbeing.

Treatment of Bulimia

Summary of treatment options

Overall the treatment of bulimia will depend on the severity of the symptoms and any associated emotional problems, such as depression, anxiety or alcohol abuse, the age of the person and the quality of their interpersonal relationships. A key issue in any psychological treatment is the person being able to work well with the clinician. In general, it is not helpful to combine different treatments or to have more than one therapist helping at any one time although it is common for people to try a number of therapies. This can be useful since no treatment is clearly better than others and recovery is most likely where the patient mostly likes and understands the therapy. However, it is important to let the therapist know how you are feeling about the therapy and whether you are in another therapy.

Psychosocial treatments

These address the person's thinking, behaviour, relationships and environment, including their culture.

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 to them and to make positive changes in their lives. They may involve the use of specific therapies such as family therapy or individual therapies including cognitive-behavioural therapy (CBT) psychodynamic therapy, interpersonal therapy (ITP) or narrative therapy. Some therapists use feminist theories to encourage the person to become more aware of the importance of social pressures on her to be thin. More research is needed before one type of psychological therapy is necessarily preferred over another.

Psychoeducation is a process whereby the person is given information about their eating disorder and the complications of bulimia. This can be extremely important to help family whanau and friends to understand the person better and to aid improvement of the disorder.

Counselling may include some techniques used in psychological therapies, but is mainly based on supportive listening, practical problem solving and information giving.

All types of therapy/counselling should be provided to people and their families and whanau 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.

Medication

Antidepressants have been found to be helpful in the treatment of bulimia. 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 taking medication at this time you should talk with your doctor about the potential benefits and problems associated with each particular type of medication in pregnancy.

Hospitalisation

Hospitalisation may be suggested where there are serious concerns about the person's physical health.

Complementary therapies

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

Psychosocial treatments

Family therapy

In general, family therapy looks at the whole family as a system and may see the bulimia as a symptom of something breaking down in that system. Family therapy ideas suggest that when one person in a family has a major problem, such as an eating disorder, it will affect other family members. Family therapy encourages family members to look at their strengths, and can often be challenging as it highlights issues that other members of the family may be having which may be contributing to the bulimia.

A family therapist may want to work alone with the person with bulimia for some sessions, to give them the opportunity to talk without the family whanau being present. There may also be regular sessions for the parents and other family whanau members.

There are several 'schools' of family therapy, each with slightly different ideas on how family relationships can be helped to improve. Some family therapists work singly, some with a co-therapist and some use one-way mirrors with other therapists watching the session from an adjoining room in order to get a better appreciation of the family interactions. Most experts agree that family therapy is extremely important for children and teenagers but there are no studies of its effectiveness in bulimia.

Some community agencies such as specialist eating disorders units run by public hospital services offer family therapy free of charge. Family therapists in other agencies and in private practice often have a sliding scale of fees ranging from $60 to $200 per session.

The number of sessions required will depend on the family whanau’s needs and ability to attend and to pay for therapy. From between 10 and 50 sessions over a period of one or two years is typical in the treatment of anorexia.

Individual therapy

Individual or one-to-one therapy is likely to be one of four main kinds.

Cognitive-behavioural therapy (CBT). With CBT the focus of the therapy is on changing eating patterns and correcting the person's unhelpful beliefs about food and raising their self-esteem. For example, they may learn to challenge the idea that you have to be thin to be considered worthwhile. CBT is relatively new as a treatment for bulimia but has the advantage of having a number of studies showing that it is effective for about 70 percent of patients with uncomplicated bulimia - that is, they do not have other major mental health problems or conditions as well as bulimia. Generally about 20 sessions over six months are required.

Psychodynamic therapy. Here the focus is on learning about and changing feelings and relationship patterns which arise from the past. Feelings and thoughts about the therapist are frequently discussed. The therapy usually lasts several years and requires a high level of commitment from the person with bulimia. Short-term psychodynamic therapy has been shown to be reasonably effective but less so than CBT. However, therapists who use this form of therapy usually recommend longer-term therapy.

Interpersonal therapy (IPT). This form of therapy explores the person's current relationships. The person with bulimia identifies problem relationships and seeks to make changes to these by dealing with others in new and different ways as discussed with the therapist. The few studies that have been done suggest that IPT is as effective as CBT and may be better in the longer term.

Narrative therapy. The person with bulimia is encouraged to see bulimia as something which is outside her real self. In this way she can learn to fight the negative messages that bulimia tells her. She learns to change her story about herself from one as a victim of social forces to one as a survivor of them. Narrative therapy is popular in New Zealand but there are no studies on its effectiveness.

Costs for individual therapy are generally the same as for family therapy (see above).

Psychoeducation

Education about bulimia can be extremely important to help the person with it, their family whanau and supporters to understand this disorder and help in recovery. The health professional gives information about the disorder, different ways to handle it, and discusses any complications which may happen.

Medication

Antidepressants

There are two different groups of antidepressants used in the treatment of bulimia.

Selective serotonin re-uptake inhibitors (SSRIs)

SSRIs have their effect only on serotonin. They have less troublesome side effects than the other groups of antidepressants and can be started at an effective dose from day one. The SSRIs include fluoxetine (Prozac, Lovan, Plinzene & Fluox), paroxetine (Aropax) and citalopram (Cipramil).

Tricyclic antidepressants (Tricyclics/TCAs).

The tricyclic antidepressants work by increasing amounts of brain chemical messengers called noradrenaline and serotonin. Tricyclics have a number of common side effects so they should be started at a low dose and slowly increased to a therapeutic dose (around 150 milligrams per day). The tricyclic types of antidepressant: include nortryptiline, amitriptyline, clomipramine, doxepin, dothiepan, imipramine, and trimipramine. They are rarely used nowadays in the treatment of bulimia.

Antidepressant medications have been shown in a number of studies to reduce bingeing and purging for about 60 percent of people with bulimia. This is due not just to improvement of mood but seemingly by reducing the urge to binge.

The effective dose of fluoxetine (Prozac, Lovan, Plinzene & Fluox) and other SSRIs (see above) is 20-60 mg per day. However, the few studies with a long follow-up also show a high drop-out rate with fluoxetine. For this reason, and because it does not

change the person's attitudes to food or self-esteem, antidepressants should only be used in combination with some form of psychological therapy. Drug treatment is normally given for about six to nine months; however this remains a clinical decision based on the needs of each individual.

Almost all are tablets or capsules taken once a day. They are not addictive, but there may be a small rebound effect of anxiety and insomnia if you stop very suddenly.

(For further information on antidepressants refer to the medication section of the MHINZ booklet *Depression*.)

Other medications

Potassium. Blood potassium levels can fall as a result of vomiting. Potassium tablets (Chlorvescent, K-SR, Slow-K, Span-K) can help to restore body potassium levels although they are not effective if the patient vomits soon after taking them. Sometimes potassium levels are so dangerously low that the potassium must be replaced intravenously

Iron and vitamin B12. Generally vitamin and mineral levels are not low in people with bulimia, but occasionally iron or vitamin B12 levels do fall to levels which lead to anaemia (a condition which affects the red blood cells). Iron levels can be restored with tablets and B12 by injection.

Medicine interactions

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 be told what effects you may notice from the medication and receive clear instructions about how you should take them and what precautions are necessary. 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 increased, so they should be avoided. It is important the doctor knows all the medications (including any herbal medicines) you are taking, as some taken together can be dangerous.

Hospitalisation

Hospital treatment is rarely recommended in bulimia. However, brief hospitalisation may be recommended if the binge purge cycle is totally out of control and/or there are severe associated problems. Correcting any medical complications is also an important part of treatment either in or out of hospital.

Side Effects of Antidepressant Medications

Antidepressants - tricyclics

Generic name — Trade name	
Imipramine ..... Imipramin Nortryptiline ..... Allegron " ..... & Norpress Doxepin ..... Anten	**Common side effects** **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** **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

Antidepressants - SSRIs

Generic name — Trade name	Common side effects of SSRIs
Fluoxetine ..... Prozac " ..... Lovan " ..... Plinzene " ..... Fluox Paroxetine ..... Aropax Citalopram ..... Cipramil	**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

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 Puna 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

Mental Health and the Law: A Legal Resource for People who Experience Mental Illness, Wellington Community Law Centre, 2002. Available from Wellington Community Law Centre, Ph 04 499 2928.

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

On the Record: A Practical Guide to Health Information Privacy, Office of the Privacy Commissioner, 2nd edition, July 2000.

Protecting Your Health Information: A Guide to Privacy Issues for Users of Mental Health Services. Mental Health Commission, 1999.

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.occ.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

Groups and organisations

Eating Disorders Association, Auckland
Provides support for sufferers and families, library service, information packs, a school education field worker, telephone support, referral list

Ph 09 818 9561 (Secretary)
Fax 09 627 8493

Wellington Eating Disorder Services
Provides information, support, education, prevention and therapeutic services for people with eating disorders and their families / friends. Their community funded general service provides free or low cost services for people who do not or not yet meet DSM IV diagnostic criteria, and their government funded specialist provides specialist eating disorders services (including a six bed residential service) for the central region.

Ph 04 473 5900
Fax 04 472 0779
Email weds@xtra.co.nz

EDEN (Eating Difficulties Education Network)
Provides support, information, referral and library resources.

P O Box 78005
Grey Lynn
AUCKLAND

Ph 09 378 9039
Fax 09 378 9393
Email info@eden.org.nz

North Shore Women's Centre
Provides support groups for people living with or associated with eating disorders.

P O Box 40 106
Glenfield
AUCKLAND

Ph 09 444 4618
Fax 09 444 4626
Email women.ctr@ix.net.nz
Web www.womyn-ctr.co.nz

Eating Awareness Team
P O Box 4520
CHRISTCHURCH

Freephone 0800 690 233
Email eat@chch.planet.org.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

The Eating Disorders Association (UK)
www.edauk.com

Eating Disorders Foundation of Victoria
www.eatingdisorders.org.au

Something Fishy
www.something-fishy.org

Anorexia Nervosa and Related Eating Disorders
www.anred.com

Books

Bulimia Nervosa and Binge Eating: a Guide to Recovery by Peter J Cooper. New York University Press, 1995.

Dying to be Thin: Understanding and Defeating Anorexia Nervosa and Bulimia: a Practical, Lifesaving Guide by Ira Sacker and Marc Zimmer. Warner, 1987.

Feeding the Hungry Heart: the Experience of Compulsive Eating by Geneen Roth. Plume, 1993.

Healing the Hungry Self: the Diet-Free Solution to Lifelong Weight Management by Dierdre Price. Plume, 1998.

Overcoming Binge Eating by C. Fairburn. Guilford Press, 1995.

The Hunger Within: a Twelve-Week Guided Journey from Compulsive Eating to Recovery by Marilyn Migliore with Philip Ross. Main Street, 1998.

Why Weight? A Guide to Ending Compulsive Eating by Geneen Roth. Plume, 1989.

Mental Health Foundation Resource & Information Centre

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

Delusional Disorders	*Tourette Disorder*