



Introduction

This booklet has been compiled for the information of those who suffer from bipolar disorder (manic depression) and their families and friends.

It was compiled jointly by the members, staff, and the local and national executive committees of Bipolar Support Canterbury and Balance NZ – Bipolar and Depression Network.

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Contents

What is bipolar disorder?	3
What causes bipolar disorder?	3
Can bipolar disorder be cured?	4
Glossary	4
‘The highs’ - Mania	5
‘The lows’ - Depression	7
Bipolar disorder, children and young people	10
Suicidal behaviour	10
Keeping well with bipolar disorder	10
Mood Stabilisers	15
Antipsychotics/Neuroleptics	16
Antidepressants	18
Anti-anxiety drugs	20
Family and relationship issues	22
How to live well with bipolar disorder	24
Developing a wellness lifestyle	28
References	36
Other places to find information on Bipolar Disorder/Manic Depression	38



What is bipolar disorder?

Bipolar disorder (also known as bipolar affective disorder or manic depression) is a mental illness which occurs in around one percent of the population. It is a recurring disorder which affects how a person feels in a number of ways. Although we all have fluctuations in our mood, in people with this disorder the changes are often more pronounced and sometimes unpredictable. There may be alternating periods (or episodes) of 'high' (mania) and 'low' (depressed) mood, with periods of normal mood in between. Some individuals experience only the 'highs', alternating with normal mood. Others may experience 'mixed states' where symptoms of both mania and depression are present in the same period of time.

The frequency, duration of episodes and degree to which mania and depression affect an individual varies and may also differ between individuals.

People with bipolar disorder can have long periods of wellness (months or years) but a small proportion suffer frequent episodes that are difficult to treat with medication or other therapies.

This disorder usually occurs before a person reaches 30 years of age but can occur at any time in life. It is estimated that between 0.4% to 1.2% of the adult population have this disorder (Wells et al. 1989). Up to 5% or 6% of people may experience similar types of mood fluctuations but in much milder, less noticeable forms (Angst et al. 1998).

What causes bipolar disorder?

Many factors may combine to cause bipolar disorder. No one knows for sure, but because it is a disorder that runs in families, in some people it is likely to be caused by the genes they inherit. It is rather like diabetes or hair colour in this respect. In other people there is no family history (although this does not mean it is not genetic).

The intermittent nature of the disorder strongly suggests that its origin is chemical or biochemical. Episodes of mania and depression may be associated with changes in neurotransmitters, the substances that carry messages in the brain. For some people these may be more prone to change in times of stress or at different times of year. Some research has indicated a significant seasonal variation in the prevalence of mania and depression. It is also possible that the use of recreational drugs may trigger episodes in some individuals.

Can bipolar disorder be cured?

There is no clear answer here: certainly there is no one cure. There are some people who will never experience another episode of mania or depression again, even without further treatment, but this is rare. Usually there will be periods when the individual remains well for a given period of time, only to find the experience reoccurs. That being so, much can be done to reduce the severity or length of an episode, or even the number of episodes experienced. The best treatment is usually a combination of medication, counselling and self-management.

Glossary *(some terms you may come across)*

Affect – a term used more-or-less interchangeably with others such as emotion, feeling or mood.

Bipolar I – at least one or more episodes of mania, usually, but not always, with episodes of depression.

Bipolar II – describes the experience of recurrent depressions plus episodes of hypomania.

Dysphoria – a moodstate usually consisting of a combination of anxiety, restlessness/lethargy and depression. Dysphoria is the opposite of euphoria.

Euphoria – a sense of extreme elation generally accompanied by optimism and a sense of wellbeing and heightened activity. A person's ideas or beliefs may be associated with a sense of invincibility and sometimes become disconnected from reality (psychosis).

Hypomania – a milder form of high mood usually limited to a few days. May be associated with irritability, increased energy levels and/or productivity.

Mixed-mania – people have symptoms of mania and depression at the same time.

Psychosis – a state or any illness in which contact with reality is lost or highly distorted.

‘The highs’ – Mania

When a person is ‘high’ they are likely to behave in ways that are quite out of character. They may become very active, talk nonstop, feel superconfident and be filled with a feeling of wellbeing. The need for sleep decreases and concentration becomes difficult. The person constantly seeks out company and may become involved in spending sprees, reckless driving, unwise business ventures and inappropriate sexual behaviour. Mania may start suddenly or be preceded by hypomania and can last from days to months.

Characteristics of mania

Mania can often begin in quite a pleasant way in that the person experiences a feeling of wellbeing, may be full of energy, drive, initiative and enthusiasm, and generally finds everything and everyone pleasant and agreeable.


For many people the first indication of their mood level rising is that they require less sleep or in fact none at all. Sometimes, however, they feel irritable and argue and disagree with those around them. Others are likely to notice this increased pressure and enthusiasm because it is out of character or inappropriate to the situation.

People experiencing mania often do not see a need to change or modify this behaviour which they may find exciting and enjoyable. Some people experience an increase in creativity or insight, or may become very enterprising.

A common experience that friends and relatives report is that the person with mania won’t stop talking and talks over the top of others, interrupts or contradicts everything they say in a very off-hand, sometimes hurtful, manner.

As the episode progresses people with mania tend to become more excited and more restless. This may be seen in their speech where they are inclined to talk quickly and jump from one topic to another, and/or in their level of physical activity as they have trouble standing or sitting still and fidget continually. For some people there is an increase in religious/spiritual feelings.

Sometimes mania and depression may be present simultaneously and this is known as a mixed state. It is not always easy to recognise and may include feeling depressed during mania, racing thoughts during depression, and other combinations of mood, thought and behaviour. Probably the most striking feature of mixed states is the variability and changeability of mood. When an individual demonstrates such a wide array of varying and contrasting emotions their underlying condition may prove harder to diagnose. A proportion of all those diagnosed with bipolar



disorder may also develop some kind of rapid cycling. Rapid cycling tends to occur predominantly in females and a person experiencing this is defined as someone who has at least four episodes of mania or depression per year.

Problems that may arise

As the level of mood elevation increases, with the person becoming more excited and less in control, their judgement usually decreases and they are likely to do risky or reckless things such as driving cars at high speed, full of confidence that they are expert drivers. There is also a tendency to do whatever feels good at the time with little regard for the future consequences. People may therefore buy things they cannot afford, or go on long trips without making any prior arrangements.

Sometimes when a person is high their thoughts may be speeded up so much that they become jumbled and unclear. At this stage people may also believe that they have special powers, or are in some way different from, or better than, everyone else. Some may believe they are in fact some famous person or deity, such as the Virgin Mary or Jesus Christ. By the time they have reached this level of disturbance they are likely to be quite conspicuous and tend to be hospitalised either by friends, relatives, or the police, often under the Mental Health Act. The progression from normal mood to a level of mania sufficient to interfere with someone's everyday functioning can take anything from hours to months. Usually a few days are required before the mood reaches this extent, but there is no guarantee of this. Early diagnosis is important so that treatment may be started promptly.

People describe mania

'...if I'm ill, this is the most wonderful illness I have ever had.'

Mood

'...first and foremost comes a general sense of wellbeing. I know of course that this sense is illusory and transient...Although, however, the restrictions...are apt at times to produce extreme irritation and even paroxysms of anger, the general sense of wellbeing, the pleasurable and sometimes ecstatic feeling-tone, remains as a sort of permanent background of all experience during the manic period.'

Changes in thinking

'...the memory is complete. One idea calls up a host of related ideas without effort. I cannot but consider every question of judgment or conduct in all its aspects simultaneously, and I see the right answer at once.'



Racing thoughts

'My thoughts ran with lightning-like rapidity from one subject to another. I had an exaggerated feeling of self-importance. All the problems of the universe came crowding into my mind, demanding instant discussion and solution.'

Too much energy

'I wanted desperately to slow down but could not. Nothing helped – not running around a parking lot for hours on end or swimming for miles. My energy level was untouched by anything I did. Sex became too intense for pleasure, and during it I would feel my mind encased by black lines of light that were terrifying to me.'

Perception and sensation

'Almost always when I start to get manic I notice the change in the way I experience music. Gradually I am aware of an incredible intensity of feelings. Each note...becomes unbearably poignant. I hear each note alone, all notes together, each and all with piercing beauty and clarity.'

Behaviour

'When I am high I couldn't worry about money if I tried. So I don't. The money will come from somewhere, I am entitled, God will provide.'

'The lows' – Depression

Depression often occurs as part of bipolar disorder. As with mania, early diagnosis is important so that treatment may be started promptly. Someone who has been depressed for a long time may have stopped seeing their friends and lost all interest and pleasure in their usual activities: they may feel that their life will never be any better. Therefore they may not seek medical advice and suicide is a real danger.

Characteristics of depression

During this phase, a person may feel sad, hopeless, and miserable. They may feel helpless or simply feel nothing at all. Appetite becomes disturbed (either over-eating or under-eating), sleep is disturbed (too much or too little) and pleasure and interest in life disappears. The person feels tired, worthless, filled with guilty feelings, and concentration is difficult. This mood may begin gradually, developing over weeks or months.



Depression can result from a number of factors

Most people have experienced the depression which is a response to grief, loss or other painful life experiences. This depression usually lasts a short time, is related to specific circumstances and may cause disturbed sleep, loss of appetite, tearfulness and unhappiness around the event. Some supportive counselling may be necessary but symptoms often lessen and disappear with time. People usually recover without the need for medication.

Other types of depression may occur secondary to an illness, medicine or a drug. It may develop with a physical illness or it may be caused by the medication used to treat these illnesses, by the contraceptive pill, by some tranquillisers, or by alcohol.

Bipolar depression may occur in association with any of these or there may be no obvious issues or events that take place before it.

People describe depression

Lack of energy

Not being able to get out of bed, everything seems like too much trouble, small tasks seem tremendously difficult.

'I lie in bed till about four in the afternoon – and then I only get up because my husband comes home from work and I'm too ashamed to admit that I've been in bed all day. I can't even sweep the floor without panicking that I'd do it wrong and I cower under the bedclothes if anyone comes to the door.'

Terrible sadness that never lifts

'After I came out of hospital I felt so sad – I wept for the ecstasy I'd had and lost, I wept because it seemed like the end of the world and I wept often for no reason really except that everything was so black and seemed so hopeless ...'

Worthless thoughts

Being convinced that one is worthless, has done dreadful things, will do dreadful things.

'I get caught in the same awful trap every time I get depressed. I know I'm worthless, then I tell myself it's the depression making me feel that way, then it seems I'm making excuses for myself and not facing up to the moral failure of me and my life ...'



Feeling dead emotionally

Unable to experience pleasure or feel the concern or love of others.

'I didn't bother keeping contact with anyone – what was the point? I knew I wasn't worth knowing anyway. I was lousy company and nothing anyone said made any difference to anything ...'

Guilt

Feeling guilty about doing things and about not doing things; having second thoughts about everything one does.

'...the terrible physical lethargy, the mind still active but always a tormentor rehearsing the past with all its wrong turnings and regrets, full of self-hate mocking even the tiniest ray of hope...how much am I sick and how much just a boring old self-pitying failure? And perhaps the most nagging of all: won't I even try?'

Inability to concentrate, slowed thinking, indecisiveness

'I go to the supermarket to buy some yoghurt and stand in front of the refrigerator looking at the seemingly endless variety of brands available. I stand there for five minutes: regular or non-fat? plain or flavoured? I can feel the tears begin to sting in my eyes. Empty-handed I leave, apologising profusely to the checkout girl on my way past ...'

Wanting to escape one's mind

Many depressed people take overdoses/get drunk/try to sleep as much as they can, just to escape the feeling of being awake and depressed. Unfortunately some escape through suicide.

Cowardly or brave, it is the act of a person who has reached their limit of endurance; whose thinking has been turned upside-down to such a degree that the action presents itself as a sensible action and the 'loophole' of the chance of someone saving them is just that – a chance. To attempt suicide is not a 'plea for help', as is now popularly described, it is a flat statement of 'I've had enough. My threshold has been reached, broached.'

'The overdose I took wasn't really killing myself, I just wanted to blot out the rest of the day.'



Bipolar disorder, children and young people

For many young people signs of bipolar disorder may be first noticeable in their teens or early twenties. Occasionally some will have noticed some symptoms as children. In fact, some people have suggested that the temperamental features and behaviours of bipolar disorder can begin to emerge very early on, even in infancy (Papolos and Papolos 2000). There is, however, controversy over whether or not bipolar disorder can be reliably diagnosed in children. A number of resources have been developed for parents who are raising ‘a moody child’ (Fristad and Arnold 2003). Adolescents may also find first person accounts of other adolescents’ experiences and viewpoints helpful. Everyone Lizzie Simon interviewed for her book ‘Detour: My Bipolar Road Trip in 4-D’ was diagnosed with bipolar disorder when aged between 16 and 35 years.


‘...we do not share the same illness, for we each experience it differently. But we do share the same diagnosis. And we share the same nagging inner voice that wonders: how much of me is me, and how much of me is this illness...?’ (Simon 2002).

Suicidal behaviour

Bipolar disorder is associated with suicidal behaviour and two thirds of those who die by suicide have a depressive illness (which includes bipolar disorder) at the time they die. Furthermore, having a problem with alcohol or drug abuse may increase the risk of suicidal behaviour. It is also important to realise that euphoria can change quite quickly into dysphoria and the two states may in fact alternate over a very short period of time. Hence individuals who are experiencing mania or mixed mania may still be at risk of suicide. Nevertheless, the majority of people with bipolar disorder never commit suicide. This means that, despite the increased risk associated with bipolar disorder, most people either do not experience the life stresses or other risk factors that contribute to high suicide risk, or they get the help they need. Just because someone thinks about wanting to die does not mean they will definitely try to harm themselves. Threats of suicide or specific plans should, however, always be taken seriously.

Keeping well with bipolar disorder

Although there is as yet no known cure, bipolar disorder can often be kept under better control by the use of medication. For more information on medication options and possible combinations refer to the Royal Australian and New Zealand College of Psychiatrists’ treatment guide for bipolar disorder (RANZCP 2005).



Two of the medications that people with bipolar disorder are most likely to be on are profiled in this section.

Lithium Carbonate (Lithicarb, Priadel)

This medication has a combination of benefits in that it has been shown to:

- control episodes of mania
- act as an antidepressant
- when taken over a period it tends to even out or dampen down mood swings and so actually helps to prevent the illness from recurring (acts as a prophylactic)

The benefits of taking lithium are cumulative, i.e. the benefits increase with time, and may not develop until after the first six months to one year. Lithium treatment may not completely abolish episodes of the illness but episodes will usually be less severe and/or less frequent.

A person who has had two or three episodes of illness may decide to take lithium on a longer-term basis.

Blood testing

The level of lithium in the body takes 5–10 days to level out and lithium levels of approximately 0.6–1.0 mmol/L for maintenance are now generally recommended. Lower levels are generally less effective than the higher levels. To determine the lithium level a blood sample is drawn periodically and tested for lithium concentration. This blood sample should be taken exactly 12 hours after the lithium is taken. The daily dosage will be determined by this blood level, i.e. if the blood level is too low the doctor may advise an increase in dosage.

People with bipolar disorder are normally routinely screened by their doctor at two to three monthly intervals to check lithium levels. Kidney damage is possible if levels get too high. Low thyroid levels may occur and can be treated. Therefore periodic blood tests for renal and thyroid function are necessary. Check with your doctor.

Lithium levels may be affected by sweating due to increased physical activity or hot weather. It is therefore important to drink lots of water when taking lithium. To overcome thirst associated with lithium use, drink water in preference to high kilojoule drinks which may contribute to weight gain.



Possible side effects of lithium

Thirst, weight gain, worsening of skin rashes and acne are among possible adverse effects. Some people also develop a tremor (shake). Cognitive effects such as slower thinking or intellectual functioning, decreased memory and concentration, and lessened enthusiasm may also occur. Many people with bipolar disorder may find the cognitive side effects and changes in appearance (skin and weight) very difficult to live with.

Signs of toxicity


Dehydration can precipitate toxicity. Avoid dehydration by drinking water and by having a low-salt diet. Nausea and tremor are the first signs of toxicity. If these symptoms occur, drink plenty of water and seek medical advice if they persist.

If the lithium level does get high due to overdosing, dehydration or because you stop excreting it due to illness, a number of unpleasant symptoms may occur and you should contact your doctor. These include: weakness, sleepiness, shakes and twitches, stomach cramps, feeling sick, and in more serious cases a drunken walk, slurred speech, loss of appetite and vomiting. Should any of these symptoms develop while you are taking this medication, call your doctor immediately. They will want you to have a laboratory test done promptly to find out the concentration of lithium in your blood. If the level is not dangerous, these feelings may disappear after a short time. If you cannot reach your doctor, stop the medication until you do.

While taking lithium, diuretics (water pills) should be avoided as they raise the blood level of lithium. Any other medication (traditional or alternative) should not be taken without consulting your doctor first. If you are on a low salt diet, you should also let your doctor know. It is also recommended you discuss with your doctor any medical conditions that you may have, particularly those affecting heart or kidney function, or the thyroid gland.

Lithium should not usually be taken in the first three months of pregnancy. Breastfeeding while taking lithium is possible though not always recommended because lithium is passed to the baby through breast milk. It is important to review your particular options and circumstances with your doctor.

Many people take lithium safely for many years. The secret of success appears to be good communication between doctor and patient. Be sure to ask your doctor if you have any questions relating to this treatment. Be sure that at least one other member of your family or a significant other knows the purpose and plan of treatment.



It is important to note that stopping lithium suddenly may cause mania. If someone with bipolar disorder is intending to stop taking lithium they should discuss with their doctor the best way to gradually decrease their medication.

Sodium Valproate (Epilim)

This medication is being used more often now in New Zealand and other countries in the treatment of bipolar disorder. It was approved in the United States in May 1995 for the treatment of manic episodes.

When prescribing sodium valproate the doctor will take a number of factors into consideration, including the person's medical history and other medications. As with other mood stabilisers, ongoing treatment is often recommended with doses typically ranging anywhere from 500 to 2000mg per day but sometimes higher doses will be prescribed. Response to sodium valproate has been seen in patients after as little as five days of treatment. Other individuals may take up to several weeks to see maximum effects from the medication. Sometimes additional medications may be prescribed temporarily until the sodium valproate takes effect.

Sodium valproate can interact with any other medications and common over-the-counter medications such as aspirin. Therefore it is very important to let your doctor and pharmacist know about all medications (traditional or alternative) that you are currently taking. Sodium valproate is not addictive.

Possible side effects of sodium valproate

Some of the common side effects include nausea, indigestion, mild abdominal cramps, sleepiness, dizziness, rash, weight gain, sedation, trembling hands, brittleness of hair and some hair loss. Potentially serious side effects to be aware of include unusual bleeding or bruising, dark urine or pale stools, yellowing of the skin or eyes, severe upper abdominal pain or confusion. Signs of overdose include severe dizziness, severe drowsiness, severe trembling, irregular, slow or shallow breathing, and coma. Sodium valproate may increase the risk of birth defects and is not recommended for women who are in the first trimester of pregnancy or who are planning to become pregnant. Before conception, prospective parents should consult their physicians about sodium valproate and pregnancy. Breastfeeding is often not recommended as it is passed on to the baby through breast milk, so it is important to review your particular options and circumstances with your doctor.



Other medications

Apart from mood stabilisers (lithium, carbamazepine, sodium valproate) which act to prevent mood swings as well as dampening them down, a number of other drugs can be of benefit to people with bipolar disorder. They generally fall into two main groups – those for treating mania and those for depression.

PLEASE NOTE:

THE DRUG INFORMATION ON THE FOLLOWING PAGES IS A GUIDE ONLY. IT IS NOT INTENDED TO PROVIDE DETAILED INFORMATION ON ALL DRUGS. IT IS NOT INTENDED TO BE A SUBSTITUTE FOR MEDICAL ADVICE.

Mood Stabilisers

These drugs are prescribed to reduce the severity and frequency of the moodswings. They are used alone or in combination. Slow introduction of the drug and slow phasing out is usual for these drugs.

Class and Drugs

Lithium Carbonate

Trade Name

LITHICARB
PRIADEL

Possible Effects

Nausea, loose stools, fine hand tremor, thirst, increased urination, weight gain, oedema (fluid buildup), thyroid function affected, aggravation of psoriasis, mild intoxication - lethargy, muscle weakness, slight twitching and loss of balance.

Cautions

Take with water. Dehydration, vomiting or diarrhoea can cause toxicity
Requires blood level test.
Caution card available from GP or pharmacist.

Anticonvulsant

Carbamazepine

TEGRETOL
TERIL

Drowsiness, anorexia, dry mouth, diarrhoea or constipation, headache, dizziness, skin rashes, blurred vision, confusion, agitation (in the elderly).

Rarely: vomiting, mental confusion, allergic skin reactions, blood problems, hepatitis.

Take with food. Restrict alcohol intake.
May affect the action of other drugs and other drugs, may affect blood levels of carbamazepine. Requires blood level test.

Sodium Valproate

EPILIM

Gastric irritation, weight gain, hair loss, effects on blood, skin rashes, psoriasis.

Severe effects are pancreatitis, liver damage. However liver damage is rare.

Take with food. Restrict alcohol intake.
If vomiting, imbalance, clouding of consciousness, stop therapy and consult your doctor.

Requires blood level test.

Lamotrigine

LAMICTAL

Dizziness, unsteadiness, sleepiness, headache, double vision, blurred vision, nausea, vomiting, anxiety, runny nose, infection, tremor, diarrhoea, clumsiness, rash. Warning: rarely a serious rash and skin loss can occur requiring discontinuation of Lamictal and hospitalisation, these rashes rarely result in death

Rashes are more likely when Lamictal is used in conjunction with Valproate. If a rash occurs, contact your doctor.

Another anticonvulsant drug gabapentin has undergone clinical testing as a treatment agent in bipolar disorder (manic depression). While New Zealand participated in international trials of gabapentin it is yet to become available here. One of the side effects of this drug appears to be loss of appetite and loss of weight. More definitive data is needed on appropriate dose and titration of this agent before it is approved for widespread use. Early indications are that it may prove to be of particular use in individuals who are already overweight or who experience weight gain while using other mood stabilising agents.

Antipsychotics/Neuroleptics

These drugs are prescribed to combat psychotic features of the moodswings. They calm people and slow down their thoughts so they don't get so exhausted. They reduce the amount of strange thoughts, impulsiveness, delusions (false beliefs) and hallucinations. Usually they are used for a short time and then are slowly phased out. Abrupt cessation of the drug can bring a return of symptoms. Some side effects can be treated with anticholinergics. It is important not to stop taking the medication or change the dose without consulting your doctor.

Class and Drugs Trade Name Possible Effects

Butyrophenone

Haloperidol

SERENACE

HALDOL

Parkinsonism-like symptoms (restlessness, tremor, muscle stiffness, difficulty in swallowing) may occur in the first few days and at higher doses. Nasal congestion, dry mouth (or extra salivation), weakness, nausea, headache, sedation, dizziness, agitation, blurred vision, insomnia, vertigo, postural low blood pressure, increased heart rate, sweating, stomach paralysis, weight gain, hormonal imbalance (menstrual irregularities, breast swelling in males, impotence), urinary incontinence, aversion to light, contact sensitization and photosensitivity of the skin, reduced seizure threshold, blood disorders, obstructive jaundice.

Tardive dyskinesia (tongue rolling and facial movements) may occur with prolonged treatment and high doses.

Cautions

Avoid alcohol.

Care with driving or using machinery. Avoid excessive sunlight.

Can interact with some other medications to cause an increase in drowsiness or confusion.

Antipsychotics/Neuroleptics (continued)

Class and Drugs	Trade Name	Possible Effects	Cautions
Phenothiazines			
Fluphenazine	MODECATE (injection)	The possible effects are the same as for Haloperidol on p16	All antipsychotics/neuroleptics come with the warning to avoid alcohol and take care with driving and machinery. They may affect concentration.
Chlorpromazine	LARGACTIL		
Trifluoperazine	STELAZINE		
Thioxanthines			
Flupenthixol	DEPIXOL (injection)	The possible effects are the same as for Haloperidol on p16	
Atypical			
Clozapine	CLOZARIL	These are the most common side effects of atypical antipsychotic medications Blurred vision, constipation, urinary incontinence, drowsiness, lots of saliva, hypotension (low blood pressure), palpitations, weight gain. Rarely clozapine can lower the number of white blood cells in your blood. White cells help to fight infection so if you have fewer of them it is harder to fight infection.	Regular blood tests are required to monitor levels of white blood cells. Let your doctor know if you have Parkinson's disease, liver, kidney, heart trouble, are pregnant or planning to be pregnant.
Risperidone	RISPERDAL	Headache, hypotension (low blood pressure), restlessness, sexual dysfunction, breast tenderness and mild secretion in men and women as a result of raised prolactin levels. Prolactin is a naturally occurring hormone.	Let your doctor know if you have Parkinson's disease, liver, kidney, heart trouble, are pregnant or planning to be pregnant.
Quetiapine	SEROQUEL	Dyspepsia (stomach upset), drowsiness, hypotension.	Let your doctor know if you have Parkinson's disease, liver, kidney, heart trouble, are pregnant or planning to be pregnant.
Olanzapine	ZYPREXA	Weight gain, drowsiness, and rarely, sexual dysfunction.	
Aripiprazole	ABILIFY	Headache, tiredness, weakness, restlessness, nausea, vomiting, lightheadedness, trouble sleeping, fast heart rate, rarely stiffness, cramps, agitation, hypersalivation.	Let your doctor know if you have Parkinson's disease, liver, kidney, heart trouble, are pregnant or planning to be pregnant.

Antidepressants

Class and Drugs Trade Name Possible Effects

SSRI (Selective Serotonin Reuptake Inhibitors)

Citalopram	CIPRAMIL CELEPRAM ARROW	All SSRIs have some of the following side effects: nausea, diarrhoea, agitation, dry mouth, weight changes. For most antidepressants, a doctor's advice should be followed if other serious illnesses are present.	Antidepressants may take at least 10-14 days to start to work. A few temporary side effects may occur. If these don't go away, your doctor may want to change the dosage or change to another drug which suits you better.
Fluoxetine	PROZAC FLUOX PLINZENE		
Paroxetine	AROPAX PAXAM		

Tricyclic

Nortriptyline	NORPRESS	All tricyclic drugs have the following effects to a varying degree: drowsiness, dry mouth, constipation, blurred vision.	All antidepressants come with the recommendation that you avoid alcohol and take care with using machinery and driving vehicles.
Amiripityline	AMITRIP		
Clomipramine	ANAFRANIL		
Dothiepin	PROTHIADEN		
Imipramine	IMIPRAMIN	Much less common side effects are skin rashes, weight gain, gastric disorder, hypertension, fast pulse rates, confusion, seizures.	
Desipramine	PERTOFRAN		
Trimipramine	SURMONTIL TRIPRESS		

NASSA (Noradrenergic and Specific Serotonergic Antidepressant)

Mirtazapine	REMERON	Vivid dreams, constipation, dizziness, drowsiness, dry mouth, weight gain, flu symptoms, rarely lowers immunity, swelling/ fluid retention, shortness of breath.	Let your doctor know if you have liver disease, kidney disease, a low blood count, have taken MAOI's lately.
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Note: This medication will be funded by Pharmac NZ Late 2009.

Antidepressants (continued)

Class and Drugs	Trade Name	Possible Effects	Cautions
MAOI (Monamine Oxidase Inhibitor)			
Phenelzine	NARDIL	MAOIs may cause some or all of the following: dizziness, constipation, diarrhoea, headache, dry mouth, fatigue, postural low blood pressure.	Serious reaction possible if taken with tyramine-rich foods. Do not take without understanding the caution card from your GP or pharmacist.
Tranylcypromine	PARNATE		
Foods to be avoided when taking MAOIs			
Hard cheese (even Edam or mild Cheddar); meat and fish which are more than 24 hours old; leftovers or meat stored longer than 24 hours including game; salami and dried meat; soy sauce and fermented soy products such as Miso; Tofu; tap beer and home-brewed beer; yeast extracts such as Marmite, Vegemite and Bovril.			
MAOI drugs can interact with tyramine in these foods and in other medicines causing dangerously high blood pressure. Tell your pharmacist if you are buying over-the-counter medication like cold remedies, hay fever pills, diet pills or herbal supplements or your dentist before having a local anaesthetic.			
Reversible Monamine Oxidase Inhibitor			
Moclobemide	AURORIX APO-MOCLOBEMIDE	Transient effects are anxiety, blurred vision, dry mouth, diarrhoea, constipation, dizziness, nausea, headaches.	Caution is needed with some drugs: cimetidine, clomipramine, pethidine, selequiline, and dextromorphan. Avoid alcohol. Take care with driving and machinery.
Dietary requirements are not as strict as they are for MAOIs but you should still avoid eating large quantities of tyramine-rich food.			
SNRI (Serotonin-Norepinephrine Reuptake Inhibitors)			
Venlafaxine	EFEEXOR-XR	Headache, dry mouth, constipation, tremor, anxiety, trouble sleeping, dizziness, vision changes, rarely difficulty urinating, fast heart rate, easy bruising, increased blood pressure	Let your doctor know if you have glaucoma, heart disease, heart failure, recent heart attack, kidney disease, taken MAOI's lately

Anti-Anxiety Drugs

These drugs calm people. While they are not as powerful as antipsychotics they do have the problem that people can become dependent on them. For this reason they are used sparingly outside hospitals.

Class and Drugs Trade Name Possible Effects

Cautions

Benzodiazepine

Lorazepam	LORZEM ATIVAN LORAPAM	Benzodiazepines may cause: fatigue, drowsiness, problems with coordination and concentration, breathing inefficiency, urinary incontinence. Very rarely they cause blood problems, and further mental disorders.	For all benzodiazepines restrict alcohol and take care with driving and machinery. Side effects are enhanced by drugs which affect the brain.
Diazepam	D-PAM PRO-PAM		
Clonazepam	RIVOTRIL		

PLEASE NOTE:

THE DRUG INFORMATION ON THE PREVIOUS PAGES IS A GUIDE ONLY. IT IS NOT INTENDED TO PROVIDE DETAILED INFORMATION ON ALL DRUGS. IT IS NOT INTENDED TO BE A SUBSTITUTE FOR MEDICAL ADVICE.

Other issues relating to treatment

People who suffer from bipolar disorder are individuals so different people may suit different types, doses and combinations of medication. Some people may not fully respond to medication or simply may find medication difficult to tolerate. A range of treatment choices exists and deciding on the best approach for a particular person is a complex task. If you are diagnosed with bipolar disorder you should try to find a doctor with specific training and experience in treating it or someone with good access to other mental health professionals with this experience who can provide advice if required.

Many people do find that the most important factor in keeping stable is taking prescribed medication regularly. You will need to take extra precautions if you are changing anything in your routine that might affect your ability to take or absorb medication (e.g. diet, fluid intake, vomiting, diarrhoea, pregnancy etc).

Some people, when feeling very well, may wish to stop their medication. It is better not to do this or to change medication without first consulting your doctor.


Some people are reluctant to use medication for a variety of reasons. While the higher doses of some drugs a person may be given in hospital may produce a very slowed down effect, this is generally not permanent. Doses will be reduced. However the decision to use or not use medication longer term is a very personal one and each individual needs to have an honest discussion with the health professionals involved in their care about the advantages (or disadvantages) of medication use.

Certain other non-prescribed drugs and selected medications may need to be avoided because these can have a detrimental effect and make the illness worse or even initiate an episode of mania or depression.

For the person with bipolar disorder

Doctors can do their job much better if you are honest and open with them. This involves giving good descriptions of your symptoms and side effects and letting them know when you are unhappy with your medication. If, for instance, you stop taking your medication for any reason, it is much better to let them know than to pretend to be taking it for fear of being told off or hurting their feelings. You should be aware it could be serious to stop your medication abruptly.

Medication is often not a quick fix. Frequently, different drugs and doses may need to be tried to get the best results. These changes don't mean your doctor has made a mistake or is confused. It may be because you respond differently from others, and what you need may change as your ability to manage your illness and/or your life circumstances change.



If you have any concerns about the effects of medication you may be taking, discuss them with your doctor. It may be helpful to write down your concerns before you go, and you may wish to share them with someone you trust and take that person along with you for support. If there have been no episodes of mania or depression for a long time (for example, five years) you may request a review of the drug treatment. Some people can manage without medication.

Charges

Prescription charges vary continually as government health policies change and will continue to do so. Please consult your doctor and/or pharmacist for payment procedures and ask for the subsidies available on particular medications. Check with Work and Income (WINZ) about your eligibility for claiming a disability allowance to offset the cost of medication or other treatments.

Note

The medicines listed in this booklet are used in the treatment of mental illnesses, including bipolar disorder/manic depression, anxiety states, neurotic and psychotic conditions. Although listed according to their therapeutic class (most commonly used treatments) a particular medicine may be prescribed for a condition outside its particular class, possibly for an unrelated condition, e.g. pain, skin disorders, insomnia, nausea or vomiting. Check with your general practitioner (GP) if in doubt. For more information about medicines visit <www.medsafe.govt.nz> and <www.pharmac.govt.nz>. Also contact local pharmacies for their medication leaflets.

Family and relationship issues

How can I understand what my friend/family member is going through?

For individuals with bipolar disorder the understanding of family and friends is essential. The behaviours shown by people with bipolar disorder can have a profound effect on those closest to them, who experience consequences from the disorder as well. It is not always easy to offer sympathetic support to someone who may have been behaving erratically, angrily, recklessly or thoughtlessly. It is difficult not to take such behaviour personally and to react to it, particularly when it causes disruption or has negative repercussions. Family and friends often express the opinion that they feel they have been rejected by the individual concerned and are unsure how to respond. The more you understand this illness the more you will be able to empathise and offer useful support.

Does bipolar disorder run in families?

This is a difficult area, both in terms of the concerns it may raise for family members and because our understanding of the genetic component of bipolar disorder is somewhat limited. We can only talk about the issue in a very general way. Children of people who have bipolar disorder appear to have an increased risk of developing bipolar disorder themselves, but this is only in the region of 10-15%. The risk is higher where both parents have a mood disorder diagnosis, but this risk differs depending on circumstances and it is difficult to generalise. The risk that siblings of the person with the diagnosis will themselves have children with bipolar disorder is relatively small.

How bipolar disorder may affect relationships with others


Many people with bipolar disorder stay well most of the time but one of the problems of this disorder is that the quality and nature of relationships with others may change alongside changes in mood during an episode of illness.

Family and friends need to be able to adjust to the various changes that occur during episodes of mania or depression and they need to be able to give control back to the person when they are well and try not to 'supervise', however tempting. Sometimes relationships deteriorate so much that family and friends no longer want anything to do with their ill relative – and the person with bipolar disorder may feel betrayed by them.

When a person with bipolar disorder becomes unwell, relationships can get strained because others get frustrated:

- with having their own lives disrupted as well;
- with being constantly visited or phoned;
- with being ignored, or with being verbally or physically abused;
- with having to deal with the consequences of reckless behaviour and lack of judgement (e.g.) spending sprees, reckless driving, promiscuous sexual behaviour;
- because the individual does not control their behaviour or 'pull themselves together';
- with lack of communication;
- with the other person's ongoing negativity, criticism or negative comments;
- because they feel out of control, cannot help or don't know how to help.

If bipolar disorder affects things at home, it is also going to affect things at work and in other situations. Relationships with workmates will be affected in the same



way as with friends and relatives. In addition, some of the characteristics of mania and/or depression (e.g. impaired judgement or decision making, poor concentration, excessive tiredness) may affect the person with bipolar disorder's ability to do their work properly or safely.

Most people with bipolar disorder continue to lead a normal life when well and the disorder does not actually affect their ability to function on a long-term basis. A small group of people may continue to have difficulties with their social relationships and ability to work over a longer period of time.


Many books (see reference list) describe the lives of both famous and ordinary people who have had this disorder but have made outstanding contributions to society.

[Material in this section has been adapted from the Manic Depression Fellowship information for family and friends (2003).]

How to live well with bipolar disorder

Self-management is built on the principle that people with bipolar disorder can become experts on their own health. If we are able to recognise the early triggers and warning signs of an impending episode and implement 'coping strategies' then we can gain greater control. Examples of coping strategies include reducing stressful activities, using relaxation exercises, maintaining a regular sleeping pattern, exercising and using cognitive therapy techniques. Lifestyle regularity is important in maintaining wellness. Another useful tool may be keeping a mood diary which can provide early warning of mood changes and can also help to identify any patterns to episodes.

People who self-manage may wish to develop a Wellness and Recovery Action Plan - WRAP (Mary Ellen Copeland 2002). This lists their own specific coping strategies that can be put into effect if triggers and warning signs should start to appear. This is important because different strategies will work for different people.



There are five key concepts that provide the foundation of effective recovery work. They are:

- **Hope:** With good self-management, you will experience long periods of wellness.
- **Personal Responsibility:** It's up to you, with the assistance of others, to take action and do what needs to be done to keep your moods stabilised.
- **Self Advocacy:** Become an effective advocate for yourself so you can get the services and treatment you need, and to make your life the way you want it to be.
- **Education:** Learning all you can about bipolar disorder allows you to make good decisions about all aspects of your treatment and life.
- **Support:** While working toward your wellness is up to you, receiving support from others, and giving support to others, is essential to maintaining your stability and enhancing the quality of your life.

Beginning the journey

As you begin your recovery journey, there are two important things you need to do for yourself:

1. Get good medical care. At least once a year, and whenever your symptoms change or worsen, have a complete physical examination to determine if there is a medical problem which is causing or increasing your symptoms.

When you go to see your doctor take a complete listing of:

- all medications and health care preparations you are using
 - any new, unusual, uncomfortable or painful symptoms.
2. Manage your medications carefully. Learn about your medications, how they work, what to expect, possible side effects, and dietary/lifestyle restrictions. Take them only as prescribed.
 - Use a daily reminder.
 - Get rid of medications you are no longer using – return them to the pharmacy for appropriate disposal so that they cannot be used.
 - Don't expect medications to fix a bad diet, lack of exercise, or an abusive or chaotic lifestyle.



Symptom monitoring and response system

Through careful observation you will learn: the things you need to do every day to keep yourself well; external events that may trigger an increase in symptoms; early warning signs of an impending episode; and symptoms that indicate you are in trouble. With this knowledge, and by using the tools listed here, and others you have discovered for yourself, you will be able to develop a symptom monitoring and response system (Wellness Recovery Action Plan) that will help you keep your moods stabilised. This system would include listings of:

- those things you need to do every day to keep yourself well, such as eating three healthy meals and getting a half-hour of exercise
- external events that could trigger symptoms, such as an argument with a friend or getting a big bill, and responses that might keep this event from causing or worsening symptoms
- early warning signs – such as irritability or anxiety – that indicate your symptoms may be worsening, and a response plan
- symptoms that indicate the situation is getting much worse, such as reckless behaviour or isolation, and an action plan to stabilise the situation

Wellness toolbox

Use the following tools as part of your symptoms monitoring and response system to reduce symptoms and maintain wellness.

- talk to a supportive person
- attend a support group
- talk to your counsellor, doctor or other health care professional
- peer counselling – share talking and listening time with a friend
- structured focusing exercises
- relaxation and stress reduction exercises
- fun, affirming, creative activities
- journaling
- daily planning
- exercise
- exposure to light
- dietary improvement – avoiding caffeine and sugar

- increasing or decreasing the stimulation in your environment
- stop, analyse the situation and make a thoughtful decision on how to proceed

Crisis planning

Write a personal crisis plan to be used when your symptoms have become so severe and/or dangerous that you need others to take over responsibility for your care. Your crisis plan should include:

- a list of your supporters, their roles in your life, and their phone numbers
- a list of all medications you are using and information on why they are being used
- symptoms that indicate when you need your supporters to make decisions for you and take over responsibility for your care
- instructions that tell your supporters what you want them to do

Give completed copies of your plan to your supporters so they have easy access to it when necessary. Update your plan as necessary.

Addressing traumatic issues


If you feel your symptoms are caused or worsened by traumatic events in your past, it may be valuable to seek out a treatment programme that:

- validates your experiences
- empowers you to take positive action on your own behalf
- helps you establish connections with other people

Suicide prevention

Up to 15% of people diagnosed with depression or bipolar disorder (manic depression) end their lives by suicide. Make sure that doesn't happen to you by:

- seeking treatment early
- setting up a system with others so you are never alone when you are deeply depressed or out of control
- having regularly scheduled health care appointments
- throwing away all old medications and having firearms locked away where you do not have access to them
- keeping pictures of your favourite people in clear view at all times

- 
- instructing a close supporter to take away your credit cards, cheque books and car keys when you are suicidal
 - always having something planned to look forward to

[Material in this section has been adapted from the work of Mary Ellen Copeland (2002).]

Developing a wellness lifestyle

Develop a lifestyle that supports your wellness by:

- using self-help books to improve your self-esteem and change negative thoughts into positive ones
- enhancing your life with pets, music, and activities that make you feel good
- having a comfortable living space where you feel safe and happy
- establishing a career or a vocation that you enjoy
- keeping your life calm and peaceful
- taking good care of yourself
- managing your time and energy well
- spending time with people who are positive, affirming and fun

There are many ways of developing this lifestyle.

Exercise regularly

Those who exercise regularly tend to cope better with stress than those who don't. Exercise may increase your tolerance to stress and enable you to bounce back more quickly. Fit people who are under stress experience smaller increases in anxiety, muscle tension and blood pressure than unfit people under stress. Thirty minutes fast walking three to four times a week is good exercise, and swimming is an excellent all-round exercise, even for people who are overweight.

Learn to relax

Just as the stress response (when the body gears up for fight or flight) is automatic, so too is the relaxation response; but you need to practise regularly to become proficient. Effective techniques for relaxation include yoga, meditation and massage.



Meditation – how do I do it?

- Find a quiet spot that has few distractions. Turn off the radio, take the phone off the hook. Make yourself comfortable, loosen any tight clothing.
- Focus your attention on your breathing (slowly and deeply), or on an external object such as a candle flame, or repeat to yourself a soothing sound or word (a mantra), such as ‘relax’, ‘peace’.
- Be passive. Let go of any distracting thoughts which enter your mind. Take your time.
- Set aside a regular period of time each day to practise, say 20 minutes.

Maintain a balanced, regular lifestyle

This includes sufficient sleep and recreation, good nutrition and sustained periods of relaxation.

Change your thought patterns

Emphasise the positive things in your life: when a negative, critical thought comes to mind, distract yourself and think of something positive or pleasant. Know that some feelings are out of all proportion to the situation. Convince yourself that you are overreacting. Wait for time to pass, and do something pleasant and distracting in the meantime.

Face difficult situations

Allow yourself a specified period of time to deal with problems and then do something pleasant for yourself – see a film, go for a walk, read a magazine.

See the humour underlying the situation

Try not to take yourself too seriously. Those all-too-common embarrassing moments and lengthy monologues to friends about your gloom and doom can have a funny side. If you’re feeling low, see a humorous film rather than a heavy, sad one; read that light ‘escapist’ novel instead of a melancholic classic. If you are feeling high, don’t try to save the world today.

Give yourself a lift

Clean hair and colourful fresh clothes can improve flagging self-esteem.



Be assertive

A well-placed ‘No’ or ‘Not yet’ can be a real lifesaver for a frazzled, over-committed ego.

Keep track of yourself with a diary (journaling)

A diary is a form of reflective meditation. It can help put day-to-day occurrences in perspective, and give you insight into your feelings and other experiences. Put special photos, poems, cartoons, pressed flowers in your journal to make it a real haven. It can also be useful for noting down which times of the year you are most likely to be high or low.

Take an hour off now and then

Take regular ‘time out’ to walk, look at the trees and birds, take a relaxing hot bath, go for a swim. If work tenses you up, stop off at the park on the way home (or better still, collect the dog and then walk), or work in the garden for an hour after work. Insist on no distractions: this is your time to unwind.

Plan your recreation


A couple of hours of free time needn’t be spent in bed or in front of the television. With a bit of planning, you could be at the beach, on your way to the nursery to buy some plants, or sitting in the sun with a good book.

Take one thing at a time

For people who suffer from tension or depression, an ordinary day’s work can sometimes seem unbearable. When that happens, remember that the feeling is only temporary. Take the most urgent tasks and work on them first, one at a time, forgetting the rest for the time being. Once you have settled down and achieved something, you will find that the rest of your tasks will be much easier to do. If you feel that you can’t tackle things in this way, reflect. Are you overestimating the importance of many of the things you do? Can the task wait until tomorrow? Can you delegate it?

Be positive to others

Some people expect a lot from others, and then feel frustrated and disappointed when these people do not measure up to their own high standards. Remember that everyone has their own virtues, shortcomings, values and right to develop as an individual. Sometimes people who feel let down by the real or imagined shortcomings of others are really let down about themselves. Instead of being



critical, search out the other person's good points and praise them. This may ease a tense situation, rescue a relationship and, at the same time, help you gain a better understanding of yourself.

Be kind to yourself

Some people expect too much of themselves and get into a constant state of anxiety. They try for perfection in everything – an impossible task. Do the best you can, and don't be too hard on yourself if the result isn't perfect. Pat yourself on the back for the things you do well, but don't set yourself impossible standards and targets for everything you attempt.

Counselling and talking treatments

Various forms of psychological therapy and counselling can help in a number of ways. They may be able to reduce emotional and relationship problems that can trigger mood swings. They may be able to help us work out better ways of dealing with the stressful events that can lead to highs and lows. They may be able to help us identify habitual ways of thinking that make us more likely to become depressed or manic and help us to organise our lives more effectively. Some talking treatments, psychotherapies, focus more on talking about feelings. Others, cognitive therapies, focus more on ways in which we think about ourselves, our experiences and other people, and which may underlie our emotions and responses. Both of these, together with more general counselling, offer an opportunity to talk frankly about our thoughts, feelings and life, in a way that might be difficult with friends and family who are close to us, and can help us develop a different perspective on our problems. As with medication, different treatments suit different people and it is advisable to find out as much as possible about any particular talking therapy.

Interpersonal and social rhythm therapy suggests that stressful life events influence the course of bipolar disorder by disrupting daily routines, social patterns, and sleep-wakefulness habits. Individuals with bipolar disorder are guided to regulate their social rhythms when stressed and to address interpersonal problems linked to the onset and persistence of bipolar episodes (Joyce and Mitchell 2004).

Recurrent episodes of illness can place a strain on your relationships. Family therapy or professional relationship counselling may be helpful for you and your partner. Professional counselling may also help you to develop strategies to handle stressful situations more effectively. Your local Relationship Services centre may be helpful.

Complementary therapies


Increasingly, people are turning to complementary therapies for the relief of physical and emotional problems. There are many types of complementary therapy available: creative therapies (like art, dance, music therapy); physical (touch) therapies (like massage, aromatherapy and reflexology); exercise/postural therapies (like relaxation, yoga and Tai Chi); and dietary/herbal therapies. Most people use these therapies as well as, not instead of, more conventional approaches. They have been described as helpful in promoting relaxation, alleviating distress, focusing the mind, taking control, self expression, and feeling peaceful. Complementary and self-help treatments for depression with the best evidence of effectiveness are St John's Wort, exercise, bibliotherapy involving cognitive behaviour therapy, and light therapy (for winter depression). There is some limited evidence to support the effectiveness of acupuncture, light therapy (for non-seasonal depression), massage therapy, negative air ionisation, relaxation therapy, S-adenosylmethionine, folate, and yoga breathing exercises (Jorm et al. 2002).

Light therapy

Seasonal Affective Disorder (SAD) commonly known as the winter blues is a particular form of depression (or bipolar depression) that affects people to varying degrees during winter. It can be a problem in up to 10% of the population (USA and UK). SAD is recognised by the DSM-IV, a manual that assists with the diagnosis of illnesses like depression. Symptoms often begin in late autumn or early winter and cease in spring.

Typical symptoms are:

- changes in sleep patterns, particularly difficulty in waking, or reduced quality of sleep
- changes in eating habits, particularly weight gain and a craving for sweet or starchy foods
- depressed mood
- irritability
- decreased energy levels
- decreased socialising
- decreased sex drive
- decreased concentration



Light treatment has been shown in many studies around the world to be effective in alleviating or completely curing the effects of SAD (Golden et al. 2005). Light levels need to be between 2500 and 10000 lux (much higher than standard room lighting of 500 lux). It can be used instead of, or in conjunction with, drug therapy and has many advantages over other treatments:

- It is non-invasive, benign, and cheaper.
- It has only occasional mild and temporary side effects which might include a slight headache, nausea, sore eyes or feeling agitated.
- It is fast acting – benefits are typically noticed within 4 days (although it can be up to three weeks).
- It has a high success rate (typically 50-80% of SAD sufferers respond dramatically).

Financial issues


Many people who have an episode of mania spend lots of money during this episode and may face large debts when they recover. This can be disastrous for families and spouses, whose own life savings may also go down the drain. If this is a pattern, it may be necessary to protect large sums of money from manic sprees. Here are some ideas:

- Put money in accounts that require some notice before withdrawal is possible – such as short-term investment accounts needing three months' notice.
- Limit the number of credit cards one has – especially bankcards and store credit cards.
- Put property in the names of more than one person so that there is a potential veto when one person becomes manic.
- Avoid joint accounts.

Some people with bipolar disorder also find it difficult to continue to work when depressed. Talk to your employer about the options if you become too unwell to work for a significant period of time (i.e. longer than your sick leave allocation). Work and Income Services may be able to assist financially.

Self care for family and friends

Sustaining an appropriate level of involvement with an ill child, parent, sibling, spouse or friend is extraordinarily difficult. It is very important that family and



friends apply the self care or the principles of keeping well within their own lives. Pain, powerlessness, shame, guilt, confusion, fear, disappointment, exhaustion, and frustration are common emotions among friends and families. It may be useful to think in terms of the wisdom of the 4 Cs, ‘I didn’t cause it, I can’t control it, I can’t cure it so all I can do is learn how to cope with it’.


Family and friends must somehow negotiate the issue of how to maintain closeness and distance when someone they love has bipolar disorder. This is the puzzle of how best to draw the line between themselves and the person who is unwell. Eventual recognition that a family member’s illness may continue well into the future may provoke feelings of sadness, but also anger and resentment. These feelings need to be dealt with. In the extreme case, family and friends may have to be reconciled with hating someone they also love (Karp 2001). Family and friends need to take good care of themselves to be able to care for their loved one. Family and friends cannot take responsibility for the decisions or actions of the person with bipolar disorder. Learning to accept the things that can be changed and to let go of the things that cannot is important.

Peer support groups

‘What is Peer Support? Peer support is not like clinical support, nor is it just about being friends. Unlike clinical help, we don’t really think of each other as sick and in need of constant professional help, but instead, we understand each other because we’ve “been there,” shared similar experiences and can model for each other a willingness to connect. In peer support we come together with the intention of changing our patterns, getting out of “stuck” places, building relationships that are respectful, mutually responsible, and potentially mutually transforming. Instead of taking care of each other and thinking of each other as “sick,” we support and challenge each other and build mutually responsible relationships... the primary goal of peer support is to fully respect the individual process of change, yet responsibly “challenge” one another when we feel like we’re incapable and stuck. This means validating each other for our “personhood” rather than our “patienthood,” and leads us to see each other’s behaviour through the lens of personal experience rather than through the lens of illness.

Finally, peer support offers a culture of health and ability as opposed to a culture of illness and disability (Mead 2005).’

Not everyone wants to talk about their experiences, especially when they are well. However many people find it helpful to attend a support group to share their own feelings and to listen to, learn from and support others.



The groups in Christchurch and Dunedin got going when a few patients and family members who had attended education courses at the local psychiatric hospital advertised in the newspaper for other interested persons. Groups were formed out of which self-help support groups were set up and started meeting regularly. A separate group for family members/friends was also started. In our experience, membership of a support group for this disorder can fluctuate considerably. Some people will attend only once or twice.

If you would like to find out about support in your area contact Balance NZ – Bipolar and Depression Network as they work to encourage the development and growth of bipolar and depression support groups in New Zealand. They can be contacted at <www.balance.org.nz> or Tel: 03 366 3631. The mailing address for postal enquiries is PO Box 13266, Christchurch 8141.

Check with your local community mental health services for a list of any support groups they can identify. If there is no local support group near you, you might consider starting one yourself. Look for any local mental health consumer groups that you might be able to gain the support of, or work with, to start a group.

If there are no local mental health consumer groups, it may be easier to keep a group going if help and continuing support can be obtained from a mental health professional even though these people need not be involved in the group itself. There may be an education course at the local psychiatric unit – a good starting point. The group might be able to meet in hospital-owned premises.

The use of a room in a building where other activities are taking place would avoid loading the responsibility on to one person to be available at every meeting to open up premises and lock up afterwards.

A letter to the editor of the local newspaper or advertisements could make known your wish to set up a group, or inform others of its existence.

Advise the Citizens Advice Bureau in your area of your group's existence, giving a contact, and also tell local mental health professionals (inpatient, outpatient and community mental health services, GP practices) who would be willing to tell people about the group.

References

Angst J (1998). The emerging epidemiology of hypomania and bipolar II disorder. *Journal of Affective Disorders*, 50, 143-151.

Golden RN, et al. (2005). The efficacy of light therapy in the treatment of mood disorders: A review and meta-analysis of the evidence. *American Journal of Psychiatry* 162 (April), 656-662.

Jorm AF, Christensen H, Griffiths KM, Rodgers B (2002). Effectiveness of complementary and self-help treatments for depression. *Medical Journal of Australia* 176 (10 Suppl), S84-S95.

Joyce P & Mitchell P (Eds). (2004). *Mood Disorders: Recognition and Treatment*. UNSW Press, Sydney.

Manic Depression Fellowship. (2003). Leaflet on Drug Treatment of Manic Depression.

Manic Depression Fellowship. (2003). Leaflet on Manic Depression/Bipolar Affective Disorder: Information for Family and Friends.

Manic Depression Fellowship. (2001). Leaflet on Manic Depression/Bipolar Affective Disorder.

Mead S (2005). Training Manual on Peer Support cited in Balance NZ – Bipolar and Depression Network, Newsletter Issue 9, March 2006.

The Royal Australian and New Zealand College of Psychiatrists. (March 2005). *Bipolar Disorder: New Zealand Treatment Guide for Consumers and Carers*.

Oakley-Browne, M- A-, Wells, J- E-, Scott, K- M-, & McGee, M- A- (2006). Lifetime prevalence and projected lifetime risk of DSM-IV disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian and New Zealand Journal of Psychiatry* 40, 865-874.

Further reading about bipolar disorder (manic depression) and maintaining wellness

Monica Basco and John Rush. (2005). *Cognitive Behavioural Therapy for Bipolar Disorder* Second Edition. Guilford Press, New York.

Mary Ellen Copeland. (2004). *Living without Depression and Manic Depression: A Guide to Maintaining Mood Stability: A Workbook for Maintaining Mood Stability*.

Mary Ellen Copeland. (2002). *Wellness Recovery Action Plan*.

* Available for purchase from Balance NZ.

Mary Ellen Copeland and Shery Mead. (2004). *Wellness Recovery Action Plan and Peer Support: Personal, Group and Program Development*.

*** Available for purchase from Balance NZ.**

Frederick Goodwin and Kay Jamison. (1990). *Manic-Depressive Illness*. Oxford University Press, New York.

Julie Fast and John Preston. (2004). *Loving Somebody with Bipolar Disorder*. New Harbinger Publications, USA.

Jan Fawcett et al. (2000). *New Hope for People with Bipolar Disorder*. Prima Publishing, USA.

Mary Fristad and Jill Goldberg Arnold. (2003). *Raising a Moody Child: How to cope with depression and bipolar disorder*. Guilford Press, New York.

Kay Jamison. (1995). *An Unquiet Mind*. Knopf, New York.

Shery Johnson and Robert Leahy. (2005). *Psychological Treatment of Bipolar Disorder*. Guilford Press, New York.

Peter R Joyce, Sarah E Romans, Pete M Ellis and Trevor S Silverstone (Editors). (1995). *Affective Disorders*. Department of Psychological Medicine, Christchurch School of Medicine, University of Otago, Christchurch.

David Karp. (2001). *The Burden of Sympathy: How Families Cope with Mental Illness*. Oxford University Press, USA.

David Miklowitz. (2002). *The Bipolar Disorder Survival Guide: What you and your family need to know*. Guilford Press, New York.

Francis Mondimore. (1999). *Bipolar Disorder: A Guide for Patients and Families*. John Hopkins University Press, Baltimore.

Demitri Papolos and Janice Papolos. (2000). *The Bipolar Child: The Definitive and Reassuring Guide to Childhood's Most Misunderstood Disorder*, Broadway.

Norman Rosenthal. (2005). *Winter Blues, Revised Edition: Everything You Need to Know to Beat Seasonal Affective Disorder*. Guilford Press, New York.

*** Light boxes are available to purchase or rent from Balance NZ.**

Lizzie Simon. (2002). *Detour: My Bipolar Road Trip in 4-D*. Atria Books, New York.

Peter Whybrow. (1998). *A Mood Apart: Depression, Mania, and Other Afflictions of the Self*. HarperCollins, USA.



Other places to find information on Bipolar Disorder/Manic Depression

This booklet has been put together by members of

Balance - NZ Bipolar and Depression Network

P O Box 13266, Christchurch 8141

Ph: 03 366 3631

<www.balance.org.nz>

Bipolar Support Canterbury

P O Box 25068, Christchurch 8144

Ph: 03 366 5815

<www.bipolarsupportcanterbury.org.nz>

For more information about community resources, in the Southern Region:

Mental Health Education and Resource Centre

221 Gloucester St, 2nd Floor, Christchurch 8011

Ph: 03 366 5344 or 0800 424 399

<www.mherc.org.nz>

in the Northern Region:

National Information Service and Resource Centre

Mental Health Foundation NZ

81 New North Road, Eden Terrace, Auckland 1021

Ph: (09) 300 7030

<www.mentalhealth.org.nz>

Websites of interest

Mary Ellen Copeland <www.mentalhealthrecovery.com>

Australian Society for Bipolar Disorders <www.bipolarorders.com.au>

Child and Adolescent Bipolar Foundation <www.bpkids.org>

Depression and Bipolar Support Alliance <www.dbsalliance.org>

International Society for Bipolar Disorders <www.isbd.org>

MDF The BiPolar Organisation <www.mdf.org.uk>

Significant Others <www.bps.org>

Medsafe <www.medsafe.govt.nz>

Pharmac (Pharmaceutical Management Agency) <www.pharmac.govt.nz>



balancenZ
BIPOLAR & DEPRESSION NETWORK

Membership Form

I would like to become a supporter of Balance NZ - Bipolar and Depression Network

Name _____

Address _____

Phone/Fax _____

Email _____

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