Bipolar Mood Disorders Kit

When we're up:

We feel good, ready to save the world, super-powerful, psychic, sexy, bossy, aggressive, spend money extravagantly, are creative, overgenerous and overtalkative.
We stay up all night, stop eating until the whole thing gets spinning too fast and we might end up in hospital – crazy.

When we're down:

We want to sleep a lot, getting up in the morning is a tremendous effort, have no self confidence, are afraid of our own company, are not interested in sex, any task seems too difficult.
We need other people but feel we have nothing to offer them, feel a tremendously heavy sadness that never lifts, face and body muscles sag, we look blank, may be suicidal and hospitalised.

And when we're neither up nor down
We're just like anyone else!

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Contents:

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1. Introduction

Bipolar mood disorder, also known as manic-depressive illness, is a common illness characterised by recurrent episodes of mania and major depression. A person with bipolar disorder experiences swings of mood from excessive highs (hypomania or mania) to profound hopelessness (depression), usually with periods of normal mood in between. There are many patterns of bipolar disorder: some people may have mixed symptoms of both mania and depression at the same time, while others may have more moderate symptoms of mania (hypomania). Some people have only one or two severe episodes of mood disorder while other people might have four or more episodes a year.

Severe mood disorder has been recognised as a mental illness for centuries. It exists in all cultures and affects about one in every hundred people. Some forms of mood disorder are known to have a genetic basis and so some families have a high number of family members with mood disorders.

How common is bipolar mood disorder?

Approximately 1 in every 100 adults experiences an episode of mood disorder that is sufficiently severe to affect his or her everyday functioning. Bipolar disorder affects both men and women and is known to occur in all countries and cultures. Between 13-20% of people diagnosed with bipolar disorder have a rapid cycling form of the illness where mood switches rapidly from depression to hypomania within hours or days. Rapid cycling mood disorder tends to be more common in women than in men.

What are the patterns of mood disorder?

Most people with the illness experience their first serious mood episode in their 20's but it can start earlier or later in life and can be diagnosed in children as well as adults. Early episodes of illness are usually triggered by emotional stress, or physical illness, or trauma. The first episode of illness is most commonly a depressive illness and bipolar disorder may not be diagnosed until treatment with antidepressant medication triggers a manic illness. Recognition of bipolar mood illness can often be difficult and many people are not diagnosed until they have experienced a number of years of severe mood swings. People tend to seek treatment for depression and not for the periods of elation so the disorder is often mistakenly diagnosed as depressive illness.

2. What is Mania?

Mania is a range of feelings of elation and high activity. Mania can range from extreme feelings of well being and elation (hypomania) through to manic illness where the person is clearly unable to cope.

Hypomania

Activity and thought speeds up; there is less need to sleep, mood is high and self confident, with a sense of well being but there is often irritation and intolerance towards other people. Ideas flow quickly and thought processes are relatively intact. The person feels wonderfully well and in control - but in fact may not be able to see the consequences of his or her behaviour and may react angrily if confronted. Few people who are hypomanic feel "ill" so they tend to refuse medication or any suggestions that they should seek help. Perception is heightened - many

people are very creative in this phase of mania. The person is easily distracted and will move quickly from one idea to another. Libido often increases and the person may have sex indiscriminately or form sexual relationships without considering the consequences or taking precautions against pregnancy or sexually transmitted infections. Hypomania can look very much like an exaggeration of the person's normal personality and it is often difficult to get the person to seek help or for health professionals to recognise this as part of an illness. This phase of illness can persist for weeks or months – particularly if the person is getting a lot of support and is being cared for and encouraged to eat and drink and rest.

Acute Mania

If hypomania is not treated, the lack of sleep, inability to eat and drink, and the high level of activity may lead to the person developing acute mania after a few days. In mania, thinking is disjointed and distorted and may not make sense to other people. The person may be talking so fast that other people cannot understand the flow of thoughts. Hallucinations and delusions are common and may appear very real to the person. Religious ideas are common eg: being a messenger of God, feeling especially chosen, or in touch with a higher being. The person is at risk of accidental injury and is usually not capable of looking after him/herself. People with heart problems may be at high risk of heart attacks during acute mania. While in this acute phase, a person may spend excessive amounts of money and go into serious debt without being able to recognise what the consequences are. People who are manic may also take on risky ventures or increase gambling risks because of an increased sense of optimism and sense of luck.

Symptoms of mania include:

- Increased energy, activity, restlessness,
- Racing thoughts, increased ideas and rapid speech
- Excessive euphoria and feelings of well being
- Extreme irritability and distractibility
- Decreased sleep requirement: getting to sleep later and waking earlier
- Uncharacteristically poor judgment and inability to weigh up consequences
- Increased sexual drive and poor judgment in selecting sexual partners; vulnerability to sexual exploitation
- Denial that anything is wrong: inability to reflect on behaviour and effects on others
- Overspending – feeling that one is rich and can be generous
- Risky behaviour: driving fast, increased sense of physical invulnerability

Delirious Mania

The person appears confused and bewildered and appears very disturbed. Delusions and hallucinations (where the person thinks or sees things that are not true or not really there) may be present. This stage often follows some days or weeks of not eating or sleeping, so the symptoms may be caused by poor nutrition and physical exhaustion. Without treatment, people can and do die in this stage of manic illness. This stage is often mistakenly diagnosed as a schizophrenic illness. This stage of illness is serious: the person should either be in hospital or receiving twenty four hour care to ensure that fluid intake, medication, nutrition and rest are adequate. The person

is usually incapable of organising his or her own medical care at this stage so mental health services or a local doctor may need to be involved to get the person into care.

3. What is Depression?

Depression is the opposite of mania - there is a general slowing down of activity. Thoughts are slower; mood is low and there may be feelings of sadness and emptiness. Thinking is difficult and it is hard to make decisions. The person may be unable or uninterested in performing everyday tasks. Hygiene and self care deteriorates – the person may be unable to wash or change clothes. The person may lose interest even in activities that were previously much enjoyed such as hobbies and sports. Sleeping is disturbed - it may be difficult to get to sleep but then there may be periods of wakefulness with anxiety and agitation in the early hours of the morning followed by oversleeping into the late morning. Eating disorders are common: the person may have an increase in appetite or a total inability to be interested in or even swallow food. There is a decrease or loss of interest in sexuality. Self-confidence is low and there is a generally pessimistic outlook regarding self and others. The person may feel that life is not worth living or that impending events are too difficult to face and seek to escape them by withdrawing from all social contacts. Relating to other people seems more difficult and the person may feel irritable and angry with other people. Hopelessness and despair and a feeling that nothing will help make it difficult for the person to seek help. People who are depressed often blame others or themselves for the way they feel and punish themselves and others by telling themselves and others how they deserve to feel this way.

4. Patterns of Bipolar disorder

Not everyone has the same pattern of mood illness. Mood disorders range across a spectrum so individuals may experience their own pattern of illness. The most common patterns are:

- **Bipolar I** - the person has episodes of mania and depression that are severe enough to disrupt normal life activities and cause significant disability. The person may need hospital care during acute episodes of mood disorder but is often well between episodes of mood disorder.
- **Bipolar II** - the person has episodes of mild mania (hypomania) that generally does not disrupt normal activities and may appear as increased creativity and energy but has episodes of severe depression. People often only seek help for the episodes of severe depression in this type of disorder. Some people who were diagnosed with Attention Deficit Hyperactivity Disorder as a child are now known to develop this pattern of disorder as adults.
- **Unipolar Depression** - the person has depressive episodes only, but treatment with some types of antidepressant medication may trigger mild mania.
- **Bipolar V** - Major Depression with a family history of bipolar disorder: the person has not yet developed hypomania or mania but may be at risk in future. Families who have at least one member who has bipolar disorder also have a larger than normal number of other family members who experience depressive illness.
- **Unipolar Mania** – this is uncommon; the person has only episodes of mania but does not experience episodes of depression. Manic illness may be associated with other physical

illnesses (secondary mania). If there is no family history of mood disorder and the person has never experienced mood disorder before the current episode of manic illness then a full medical check up should be given to see if there is other physical illness present or whether medication used for other illnesses is causing the mania.

- **Bipolar 111 - Cyclothymic disorder** – the person has experienced numerous hypomanic and depressive symptoms over at least 2 years that are not severe enough or not long enough in duration to meet the criteria for a mood episode. People with cyclothymia take longer to recover from a stressful event in their lives but do not experience the severe disability associated with depressive or manic illness.
- **Schizoaffective Disorder** - the person has symptoms of mood disorder and also has some symptoms of schizophrenia such as delusions, hallucinations or thought disorder. The episodes are distinct mood changes and the person is often completely well between episodes.
- **Mixed States** - sometimes mania and depression happen at the same time: the person may be laughing and crying at the same time or feel sad but driven to high levels of activity. This state often occurs when the person is moving from a manic phase to a depressive phase of illness. A person in a mixed state of mood disorder can be more vulnerable to suicide.
- **Rapid Cycling Disorder** (4 or more episodes per year) - many more women than men develop rapid cycling moods after a number of years of mood disorder.
- **Euthymia** - a period of being well: most people with mood disorder have long periods of being completely well between episodes of mood disorder.

5. What role do genetics or family history play in bipolar disorder?

Bipolar mood disorder can be caused by a genetic vulnerability. But there are clearly environmental factors that influence whether the illness will occur in a particular child or adult. Stress, physical illness or emotional crises can trigger mood swings in people who are vulnerable. It is also likely that there are different genetic forms of mood disorder. Bipolar disorder can skip generations and take different forms in different individuals.
The small group of studies that have been done vary in the estimate of risk to a given individual:

- For the general population, a conservative estimate of an individual's risk of developing bipolar disorder is 1 percent. Disorders in the bipolar spectrum may affect 4-6% of people in the general population.
- When one parent has bipolar disorder, the risk to each child is l5-30%.
- When both parents have bipolar disorder, the risk increases to 50-75%.
- The risk in siblings and fraternal twins is 15-25%.
- The risk in identical twins is approximately 70%.

In every generation since the 1940s, there is a higher incidence and an earlier age of onset of bipolar disorder and depression. On average, children with bipolar disorder experience their first episode of illness 10 years earlier than their parents' generation did. The reason for this is unknown. It is likely that bipolar disorder and depression are now better recognised. Since effective treatments became available from the 1960s onwards, doctors have become better trained to recognise and treat mood disorders. Many older people who were diagnosed with

bipolar disorder late in life say that they experienced mood problems from childhood onwards but that since treatment was not available at the time they were forced to self medicate – often with alcohol or available drugs from the chemist – or thought that their mood disorder was simply part of their personality.

The family trees of many children who develop early-onset bipolar disorder include individuals who suffered from substance abuse and/or mood disorders (often undiagnosed). But the gene or genes that carry mood disorder also increase the ability to view the world in different ways: families where there is mood disorder also have members who are highly accomplished, creative, and extremely successful individuals in business, politics, community service and the arts.

6. Treatment of bipolar mood disorder

Psychotherapy and counselling

Both individual and group therapy are appropriate and recommended for someone living with bipolar disorder.

• **Counselling and psychotherapy** is usually supportive in nature, helping the person to develop increased coping skills to live with mood swings, education about the disorder, and learning to recognise triggers for depression and manic episodes. With specific episodes of depression or mania, additional therapy can focus on the treatment of those disorders and ways to cope with symptoms. Counselling can also help the person learn to better predict his or her own fluctuations in mood (which may be related to situational or seasonal changes) and can decrease the likelihood of episodes in the future.

• **Prevention of future relapses** of mood illness should be a focus of therapy. Learning about medication and how different medications work to reduce symptoms of mood illness is an important topic in a counselling program. Most people with bipolar disorder will take a number of medications at different times and understanding when to start and stop particular drugs can be crucial in preventing future episodes of mood disorder.

• **Looking at how mood disorder affects other areas of your life** Psychotherapy can explore the effects of mood disorder on the person's life – such as effects on relationships and employment - and the self concept the person had developed because of episodes of untreated mood disorder. People who have experienced a number of "breakdowns" may have low self esteem and a sense that they can never achieve anything worthwhile in life. Once the disorder is recognised and treated effectively with medication and counselling, many people are able to achieve far more and have better relationships with other people.

• **Relationships** many people with bipolar disorder have difficulties in relationships. This may be because early episodes of mood disorder were unrecognised or because of the stress placed on partners and family members by a person who is depressed or experiencing hypomania. Relationship counselling should focus on identifying what difficulties are caused by the mood swings of one partner and what are issues common to the relationship. Many couples survive one or two bouts of mood disorder in one partner but few relationships survive repeated episodes of mood disorder without outside help to treat the mood swings.

Cognitive behavioural counselling is a form of counselling where thoughts and feelings are examined. Many people who experience depression or manic illness have ideas and thoughts that may be a result of altered thinking during periods of mood illness. These thoughts can remain after the person is well but be damaging to ongoing mental health. For example, thinking that you are worthless is a common thought during depression but continuing to think this can damage self esteem and prevent taking on new challenges when you are well. Cognitive counselling can help to identify patterns of thinking which prevent personal growth and development.

Medications for Depression

Antidepressant drugs are used in the depressed phase of the illness. There are several types of antidepressant, each with a different mechanism of action. The most common are:

- **SSRIs (Selective Serotonin Re-uptake Inhibitors):** e.g. fluoxetine, paroxetine, venlafaxine, citapramil, fluvoxamine and sertraline: these drugs are less likely to cause switching into mania for people with bipolar disorder.
- **Tricyclic antidepressants:** e.g. amitriptyline, clomipramine, desipramine, nortriptyline, dothiepin, trimipramine, imipramine, doxepin
- **MAOIs (Monoamine Oxidase Inhibitors):** e.g. phenelzine (Nardil) and tranylcypromine (Parnate). Moclocemide (Aurorix) is a newer form of MAOI which does not interact with many of the foods that phenelzine and tranyscypromine do

If used alone, antidepressants can sometimes cause 'switching' into mania. Typically, a mood stabiliser drug is prescribed in addition to the antidepressant drug to prevent the mood switching into mania. The SSRI antidepressant drugs can have an effect within four to five days but the older tricyclic and MAOI drugs can take several weeks to have an effect on depressed mood. The tricyclic drugs and the MAOI drugs have a number of side effects and are usually only now prescribed when there has been a poor response to the SSRI drugs.

Medications for Manic illness

Manic illness is a medical emergency and the person needs to be calmed. People can and do die during manic illness from exhaustion, heart failure or dehydration. Antipsychotic or neuroleptic drugs are usually given to calm the person, reduce activity levels and enable sleeping and eating. Some commonly used in Australia are clonazepam, haloperidol, chlorpromazine, quetiapine, risperidone (Risperdal) or olanzapine (Zyprexa). Anticonvulsant mood stabilising drugs such as carbamazepine (Tegretol) and sodium valproate (Epilim) are also used to treat manic illness. Lithium is effective in reducing manic symptoms but may take a few days to reach a level where it calms manic excitement.

Electroconvulsive Therapy (ECT)

Electroconvulsive therapy is sometimes used to treat acute mania if the person cannot take some medications because of other physical problems. ECT can also be used if the person is severely depressed, not eating or is at high risk of suicide. ECT works more quickly than drugs to relieve symptoms of depression and mania and does not have the side effects of many medications. A

small current of electricity is passed through the brain after the person has been given an anaesthetic and a muscle relaxant. Some people find they have memory problems after ECT treatment. These problems can be reduced if the treatment is given on one side of the brain only. Untreated mood illness and treatment with antipsychotic and antidepressant medications over a period of time can also cause memory loss but memory loss after ECT is more noticeable because it appears to be sudden.

Hospitalisation

Hospital care may be needed if the person is unable to eat or drink or sleep because of manic illness. Treatment with anti-manic drugs should be carefully supervised so hospital care may be necessary to supervise medication and ensure that the person is eating and drinking fluids. Hospital care may also be necessary if the person is acutely suicidal or is self harming or is at risk from manic behaviour. Family members and carers may also need some respite if the manic illness has been going on for some days or weeks. Living in a psychiatric hospital can be stressful in itself and the person should be discharged home as soon as possible. This may mean home visits from a mental health worker or daily visits to the doctor to supervise medication, monitor side effects of medication and ensure that the person is eating and drinking fluids.

Self Help and support groups

Support groups are a way to gain emotional and social support from other people who have experienced similar illnesses. Once the episode of illness has subsided, the sharing of coping strategies and the experience of common symptoms of mood disorder can help people come to terms with the disorder and learn how to prevent future episodes of illness. These groups also promote the person's independence, self responsibility and stability.

Support groups provide a different experience from medical treatment or counselling. Groups can vary depending on who else is in the group. The strength of a support group is in the experience of the participants and their ability to learn from each other. People who are currently manic or very depressed may not be able to participate in a support group and should wait until they are well enough to cope with group interaction. Support groups are not a substitute for competent medical care and medication and professional counselling.

The Mental Health Information Service can put you in touch with support groups if they exist in your area or give some advice and help to set up a group. (see resources at the end of this kit) Internet support groups can also work well for people who cannot find a group in their local area. There are links on the Mental Health Association web page www.mentalhealth.asn.au to internet support groups for people living with bipolar mood disorder.

Counselling and Therapy

Counselling and psychotherapy involves working with a counsellor or therapist on developing inner strengths, capabilities, resources and potential. There are many forms of psychotherapy and many types of practitioners. It can therefore be very confusing when starting to look for a psychotherapist. General practitioners, local community health centres, referrals from practitioner's professional associations and word of mouth are a few ways of finding a therapist.

People in support groups may also be able to recommend good therapists for particular disorders.

Some things to look for in a counsellor or therapist:

- Knowledge of mood disorders
- Up to date knowledge of medications used to treat mood disorders
- Willingness to liaise with treating doctors and other health professionals involved in your care
- Plan or program for the counselling
- Goals of counselling

7 What Can I Do To Help Myself?

Bipolar mood disorder cannot be 'cured', but many people successfully prevent serious episodes from developing, take early action to reduce the effects of mood swings on their lives and lead productive and creative lives. It is not all negative: the mood changes and altered perceptions during mood swings can enhance creativity and personal growth. Many people who are high achievers in the literary, artistic and musical worlds have experienced mood disorders.

Some general guidelines are:

- Educate yourself about the illness and its treatment. There are support groups and internet sites for people with bipolar disorder who can provide a wealth of information and practical advice.
- Become aware of your mood states and learn to recognise the warning signs of an impending relapse. If treated early, a full relapse may be prevented so if you recognise the signs seek help from your doctor as soon as possible.
- Be an active consumer of health care services: find a good doctor or health worker who you feel you can work with. You have a right to seek a second opinion if you are not satisfied with the care you are getting.
- Take your medication as prescribed by your physician. Remember that bipolar disorder in most people requires long-term treatment to prevent relapses. Discuss with your doctor regularly about how long you should take prescribed medication. When you feel well, it can be tempting to stop the medication, but this is the most common cause of relapse.
- Structure your life as best you can. There is some evidence that maintaining a regular structure to your daily activities and having adequate sleep reduces the risk of relapse.
- Take regular exercise: exercise can help symptoms of depression
- Establish a regular sleep pattern: people with mood disorder are more vulnerable to disrupted sleep. If you work shift work you need to be especially careful about getting adequate sleep.
- Avoid artificial stimulants and depressants like alcohol and other recreational drugs. These can precipitate mood episodes and make it more difficult to control symptoms of both manic illness and depression.
- Enlist the support of family and friends and encourage them to find out more about the illness.

8. Families and Friends

Bipolar disorder can be devastating for both the person with the illness and their friends and family. Here are some practical ways that you can give your support:

• **Encourage the person to continue taking his or her medication and to stick to their clinic appointments.** People with bipolar disorder can often be tempted to stop their medication when they feel 'well' or because they miss the 'highs' of mania. Some medications can cause undesirable side effects and may lead to individuals stopping treatment. One of the most common causes of relapse is when people do not take their medication as directed, so if the person is tempted, remind them about the consequences of stopping. If side effects from medication are the problem, encourage the person to see his or her doctor because a dose adjustment or changing to another medication may help.

• **Become aware of the warning signs of an impending mood episode** and, when the signs emerge, encourage the person to visit his or her doctor as soon as possible. Often caregivers or friends can spot the symptoms earlier than the person with the illness and a change in medication may be enough to prevent a mood episode developing further. Apart from changes in mood, warning signs could include:

- Changes in sleep pattern
- Changes in levels of energy (high or low)
- Problems paying attention and concentrating
- Changes in grooming or dress
- Increase in number of activities and projects
- Disorganisation and irritability

• **Develop a plan with** the person when things are going well about how you can both work to prevent future episodes developing into disasters: who would you contact, what changes would need to be made in medication, what hospital would you go to.

• **Help the person make plans in advance** to limit some of the damage that can be done during a manic episode. For example, make an agreement to withhold credit cards, car keys etc. Can you set up accounts so that large amounts of money can't be accessed quickly? Can you tie up money in separate accounts so that only small amounts of money are accessible if the person becomes manic? Separate your own financial affairs from the person's affairs so that you are not at risk financially.

• **Financial management and guardianship:** People who have a history of unwise financial judgments during previous manic episodes can make an application to the NSW Guardianship Tribunal to have a financial manager appointed to protect their financial affairs in the future. Contact the Guardianship Tribunal on 02 9555 8500 toll free on 1800 463 928 or visit the website at www.gt.nsw.gov.au or the Office of the Protective Commissioner 1300 360 466 for further information. This service is free.

You can also appoint a power of attorney although in practice; many people when manic can easily override a power of attorney. A power of attorney may be useful during depressive episodes when the person may have difficulty paying bills and managing his or her finances.

Suicide and self harm

There is a higher risk of suicide in people with bipolar disorder, so be vigilant for any suicidal behaviour and seek help from the doctor or your health worker. People are most vulnerable when they are experiencing a mixed state: they may look active and positive but there is an underlying depression and disordered thinking. This often happens at the end of a manic episode before the person appears clearly depressed.

People who are suicidal often make preparations to wind up their affairs and make plans for the care of family members after their death so watch out for signs of these activities. Impulsive comments about wanting to end it all or joking about life not being worth living should be taken seriously. Ask the person directly if they are thinking of harming themselves. Discuss what can be done to keep the person safe. Removing large amounts of medication from the house, removing weapons and other implements that can be used to self harm can prevent an impulsive attempt. There are several support groups for people with bipolar disorder or their friends and carers as well as telephone suicide prevention lines. These can be a source of valuable information and advice.

9. Where to Get Help?

- Your Community Health Centre (see Community Health Centres in the White Pages)
- Your Community Mental Health Team (see Living in Your Community in the White Pages)
- Your GP
- Telephone Counselling Service: Lifeline 131 114, Salvo Careline 02 9331 6000,
- Kids HelpLine 1800 551 800.
- Support groups: ask your doctor or health worker about available groups in your area
- Pastor, church groups, youth groups can provide emotional and social support
- Mental Health Crisis Team (see Living in Your Community in the White Pages)
- Salvo Suicide Prevention Line 02 9331 2000
- Mental Health Information Service (for services in your area) and information about current support groups, tel 1300 794 991

10. Further Research and sources of information

Australian websites and contacts:

- **depressioNet** www.depressionet.com.au - Information, help, support groups.
- **Reachout** www.reachout.com.au - National Youth Suicide prevention site.
- **www.blackdoginstitute.org.au** specialist Mood Disorders Unit Prince of Wales Hospital Hospital Rd, Randwick Tel: (02) 9382 4523 Fax: (02) 9382 8208 Runs clinics for people with bipolar disorder and depression and has a consumer resource centre.

- **www.beyondblue.org.au** has a resource listing of experiences of bipolar disorder and a directory of services for bipolar disorder in Australia**. BrightblueVoices** is a subgroup advocating for people living with bipolar disorder.
- SANE Australia www.sane.org has information about psychotic illnesses, schizophrenia and bipolar disorder. Helpline 1800 688 382
- Association of Relatives and Friends of the Ill (ARAFMI) 9332 0700/1800 655 198 (rural NSW) www.arafmi.org support for families and friends of people living with mental illness.

USA Websites:

- United States National Institute of Mental Health://www.nimh.nih.gov/publicat/bipolar.cfm#bp1 Bipolar Disorder: A detailed booklet that describes symptoms, causes, and treatments, with information on getting help and coping.
- Child and Adolescent Bipolar Foundation
  Phone (USA) (847) 256-8525
  Web site: www.bpkids.org
- The Centre for Mental Health Services
  Phone: 1-800-789-2647
  Web site: www.mentalhealth.org
- Depression and Related Affective Disorders Association
  Phone: (410) 955-4647
  Web site: www.drada.org
- Depression Central
  Phone: (212) 876-7800
  Web site: http://www.psycom.net/depression.central.htm
- National Alliance for the Mentally Ill
  Phone: 1-800-950-NAMI (6264)
  Web site: www.nami.org
- Depression and Bipolar Support Alliance
  Phone: 1-800-826-3632
  Web site: www.ndmda.org
- National Foundation for Depressive Illness
  Phone: 1-800-239-1265
  Web site: www.depression.org
- National Institute of Mental Health
  Phone: (301) 443-4513
  Web site: www.nimh.nih.gov
- National Mental Health Association
  Phone: 1-800-969-NMHA (6642)
  Web site: www.nmha.org

- **Child and Adolescent Bipolar Foundation** http://www.bpkids.org/learning/about.htm Children and bipolar disorder booklet
- **The International Society for Bipolar Disorders** www.isbd.org

- **BP magazine** www.bphope.com national magazine for people living with bipolar disorders. BP magazine PO Box 59 Buffalo NY 14205-9716 USA phone (USA) 1-888-834-5537
- http://bipolar.mentalhelp.net/ – All About Bipolar
- www.mentalhealth.com - Internet Mental Health
- www.bipolar.com - Bipolar Website by GlaxoSmithKline intended for US residents only.
- www.a-silver-lining.org - for Bipolar Disorder
- www.DBSAAlliance.org United States Depression and Bipolar Disorders Alliance

11. Support Groups

Some support groups are organised through the Mental Health Association; other groups are run by local organisations and health services.

Please check with the Mental Health Information Service by phone on 1300 794 991 for up to date details about support group meetings and a phone contact for the group. Because these groups are run by volunteers, may be time limited and are sometimes closed to new members, we do not publish details of these groups.

12. Further Reading

Basco Monica Ramirez and Rush John A. *Cognitive Behavioural Therapy for Bipolar Disorder*. Guilford Press, NY, 1996.

Copeland, Mary Ellen *Living without Depression and Manic Depression.* Her sequel to The Depression Workbook. Step-by-Step guidance for overcoming depressive disorders in a workbook format. Paper, 1995, New Harbinger Publications, Inc.

Goodwin, F. and Jamison, K. *Manic depressive illness.* Oxford University Press, New York, 1990. The most comprehensive and encyclopaedic work about mood disorders and manic depressive illness. Extensive list of references and scientific research about mood disorders.

Jamison, Kay Redfield. *An Unquiet Mind: a memoir of moods and madness*, Picador, London 1996 Comments: Dr. Jamison's personal testimony of her own struggle with manic-depressive illness since adolescence, and how it has shaped her life.

Jamison, Kay Redfield *Touched with Fire: manic depressive illness and the artistic temperament.* Free Press, Macmillan, N.Y. 1993.

Joyce, Peter and Mitchell, Philip *Mood Disorders: recognition and treatment*. UNSW Press, Sydney, 2004. Available from www.unswpress.com.au. An academic and clinical update of the causes and treatment of mood disorder by some of the leading researchers in mood disorders.

Kelly, Madeleine *Life on a roller coaster: living well with depression and manic depression.* Simon and Schuster Australia, 2000. Cost: $24.95

Lyden, Jacki *Daughter of the Queen of Sheba: a memoir* Hodder Headline Australia, Rydalmere,1998. A daughter writes about childhood and her memories of her mother's struggle with manic depressive illness in a country town in America.

Miklowitz, David J and Goldstein Michael J *Bipolar Disorder: a family focussed treatment approach* Guilford Press New York 1997 ISBN 1 57230 283 6 (available from The Written Word PO Box Q383 Sydney 1230 ph 1800 636 748

Monkey See Productions *Manic Depressive Illness: a guide to living with it*. (Video, 47 minutes). Positive images of people with manic depressive illness and information about treatment. $35.+$5.50 postage. Monkey See Productions PO Box 159 Blackheath, NSW 2785 ph 02 4787 1366. Website www.monkeysee.com.au.

Orum, Margo *Fairytales in Reality.* Macmillan Sydney 1996. Margo Orum is a psychologist and writer who speaks about her own experiences of manic illness and depression. Contact: www.seraline.com/bipolar. Order from PO Box 282 Ryde NSW 2112. Cost - $16 includes postage.

Phillips, Neil *Too Blue: a book about depression.* Written for young people who have mood disorder or who has a family member with a mood disorder: a delightfully illustrated book about depression and manic depressive illness. Explains symptoms and treatment in easy to read language – read all about Major Depression and Captain Mania. Shrink-Rap Press, Sydney, 1999. ISBN 0 9585604 1 2. Available from PO Box 187 Concord West NSW 2138, ph 02 8765 0222 website www.shrinkrap.com.au

Real, Terrance. *I Don't Want to Talk About It. Overcoming the Secret Legacy of Male Depression.* Real discusses his view of depression in men as a hidden or "covert" epidemic, explaining how male stereotypes prevent many men from confronting the illness. 383p, hardcover, 1997, Simon & Schuster Inc. ISBN 0-684-83102-3.

SANE Australia *About Manic Depression* by SANE Australia - 1800 688 382 website www.sane.org)

The SANE Guide to Treatments: A guide to treatments for people seriously affected by mental illness (SANE Australia - 1800 688 382)

Waltz, Mitzi *Bipolar disorders: a guide to helping children and adolescents*. O'Reilly and Associates, Sebastopol, CA, 2000. www.patientcenters.com

William S Appleton. *Prozac and the new antidepressants* Penguin Books, Harmondsworth, 1997.

mental health association nsw inc

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