

Depression

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

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Introduction

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

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

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

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

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

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Depression

Temporary moods of being depressed are a common and often normal reaction to the stress of our everyday lives. With clinical depression or a major depressive disorder (the medical terms for depression) the low mood continues and you may have a number of other symptoms, (which are listed below under 'Symptoms of depression').

Up to one in four women and one in ten men can expect to experience depression at some time in their lives. There is some evidence that it is becoming even more common in western countries. Depression can start at any age - from childhood through to old age. Most often it starts in the mid-20s, and it is more common in the 25 to 45 year-old age group.

Symptoms of depression usually develop over days or weeks, though many people have a period of anxiety or mild depression which lasts for weeks or months beforehand. The duration of an episode can be variable, but without treatment depression typically lasts for six months or more.

There is no medical test to diagnose depression. A diagnosis is made when the person has some or all of a number of typical symptoms. For this reason it is important that a doctor or other health professional gets a full understanding of the difficulties a person has had, both from the person and their family or whanau or others who know them well, if there are any symptoms of depression.

While depression is the most common cause of these symptoms, the same picture can be seen with the depressed phase of bipolar affective disorder (manic depression). They are also seen in some medical conditions. For this reason it is important for your doctor to do any tests necessary to exclude these conditions.

Some forms of depression may be seasonal. A person with this kind of depression (called seasonal affective disorder) will be well during summer, but may become depressed during the winter. This is more common the closer to the south or north pole that you live (ie, the shorter the days during winter).

The majority of people with depression are never diagnosed or adequately treated. This is a pity because depression can be effectively treated, and people will usually recover from it. However, the earlier effective treatment is started, the better their chances of recovery.

Symptoms of depression

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

The symptoms of depression are often divided into three categories - mood, physical, and cognitive (related to thoughts and beliefs) symptoms. Some people will also have anxiety symptoms.

Very severe depression can result in symptoms of psychosis (loss of contact with reality). For a diagnosis of depression to be made, mood symptoms and some or all of the other symptoms must have been present for at least two weeks.

Mood symptoms of depression

- **Persistent low, sad or depressed mood** can be described in varying ways by people, especially if they are from non-European cultures. The person may describe feeling empty, having no feelings, or may complain of pain.
- **Loss of interest and pleasure** in usual activities. This is a reduced ability for enjoyment. It includes loss of interest in sex.
- **Irritable mood.** This may be the main mood change, especially in younger people, and in men (especially from Maori and Pacific Nations ethnic groups).

Physical symptoms of depression

- **Change in sleeping patterns.** Most commonly reduced sleep, with difficulty getting to sleep, disturbed sleep, and/or waking early and being unable to go back to sleep. Some people sleep too much. Most people with depression wake feeling unrefreshed by their sleep.
- **Change in appetite.** Most often people do not feel like eating and as a result will have lost weight. Some people have increased appetite, often without pleasure in eating. This is often seen in those who also sleep more.
- **Decreased energy, tiredness and fatigue.** These feelings may be so severe that even the smallest task seems too difficult to finish.
- **Physical slowing or agitation** often comes with severe depression. The person may sit in one place for periods and move, respond and talk very slowly; or they may be unable to sit still, but pace and wring their hands. The same person may experience alternating slowing and agitation.

Cognitive symptoms of depression

- **Thoughts of worthlessness or guilt** involve loss of confidence in self and excessive guilt about past minor wrongs. As a result of feeling bad about themselves, people may withdraw from doing things and from contact with others.
- **Thoughts of hopelessness and death.** The person may feel there is no hope in life, wish they were dead or have thoughts of suicide.
- **Difficulty thinking clearly.** People may have difficulty in concentrating. They may not be able to read the paper or watch television. They may also have great difficulty making even simple everyday decisions.

Associated symptoms of depression - anxiety

Anxiety symptoms are very common as part of depression but as the depression resolves these symptoms usually stop.

- Excessive worry or fear, with associated physical symptoms such as muscle tension, pounding heart, dry mouth.
- Panic attacks. Sudden episodes of extreme anxiety and panic with physical symptoms of fear.
- Phobias. Specific fears regarding situations, objects or creatures.
- Excessive concern about physical health.

Symptoms of psychosis

Symptoms of psychosis usually take an exaggerated form of the cognitive symptoms listed above. The person may have unusual or altered beliefs or hear voices when there is nobody there. These may be about:

- poverty or excessive debts
- extreme guilt, for example, feeling personally responsible for wars or starvation
- physical disease, for example, organs not working or insides rotting
- being killed or struck down by God for perceived sins or bad deeds
- needing to kill themselves for sins or misdeeds
- being dead.

If a person seems to be showing psychotic symptoms it is important to make sure that their experiences are outside of what is considered normal or acceptable within their culture. Most mental health services have cultural consultants or services which understand the nature of the illness and address any specific cultural or spiritual concerns.

Outlook for depression

The course of depression is variable. Without treatment, an episode may last six months or more. With treatment, 70 to 80 percent of people will recover much sooner. In the majority of people, there is complete recovery and return to their usual activities and relationships. Twenty to 30 percent of people will improve but still have some symptoms of depression persisting for months or years later. In a minority (five to ten percent) there is little improvement and the person remains unwell for two or more years. Some people only ever have a single episode of depression. However 50 percent or more of those people who have one episode of depression will have one or more further episodes at some time in their life, perhaps with longer periods of wellness in between. Unfortunately, some may not recover completely between episodes. Early access to treatment increases the chance of a full recovery.

Risks for people with depression

Delays in accessing care may increase the severity of the condition, cause poorer response to treatment, and may result in long-term unwellness and ongoing problems.

There is some evidence that the more episodes a person has, the higher the chance of further episodes. Having a good relationship with your doctor or other treatment professional, continuing treatment where this is advised, learning about depression and having a clear plan to maintain wellness are most important.

Alcohol and/or drug abuse commonly occur with depression, particularly where it is severe. Early recognition and treatment of co-existing alcohol and drug problems are critical to promote recovery.

The **risk of suicide** in people with depression is significant. The lifetime rate of attempted suicide is 30 to 50 percent of people with depression. About ten to 15 percent actually commit suicide. The risks are highest if the person is over 55, and having an episode of depression. The time of greatest risk may be as the person begins to recover from an episode. It is important that any expressed suicidal thoughts or urges are taken very seriously. Having access to the best possible care can reduce the occurrence of suicide.

Violent behaviour in people with depression is rare. However, a very small number of people with severe depression may commit murder-suicide involving their loved ones. This is likely to be a result of severe feelings of hopelessness and a belief that the world is a bad place from which their loved ones must be spared. Again, prompt treatment can prevent things reaching a point where such tragedy occurs.

Myths about depression

NOT TRUE *Depression is a sign of a weak character.*

The fact is that depression can strike anyone. While some particular personality types are more likely to develop depression, the vast majority of people who develop the condition have been previously healthy and led normal lives.

NOT TRUE *People with depression can just 'snap out of it' or just choose to 'pull their socks up'*

In reality, one of the most disabling symptoms of depression is the fact that it saps the will and makes doing many things an enormous effort. Depression is an extremely unpleasant experience, and most people would do anything to get well.

Causes of depression

The exact cause of depression is unknown. There is evidence to suggest that depression is an illness. There are also many theories regarding further aspects of this diverse condition. Different causes may operate in different people. This may be why there is variation in the way depression develops, in the symptoms, and in the course. Some facts about the causes of depression are:

- There is clear genetic (inherited) factor in the cause of the condition. If someone in the family has depression, relatives have an increased risk of developing it. The overall risk is one in four for women, one in ten for men. If a parent, brother or sister has the condition, this risk is up to three times greater. There is also an association between alcoholism and depression in some families, with men having increased risk of alcoholism, and women increased risk of depression.
- A number of abnormal laboratory findings are seen in groups of people with depression, compared with groups who are well. These findings are not diagnostic, in that they are not seen in all people with the condition, but they are more frequent when the depression is more severe. The findings include sleep changes seen on recordings of brain electrical waves during sleep; changes in the daily cycle of levels of a hormone called cortisol, and changes in the regulation of thyroid hormone.
- A number of different kinds of brain scan show changes in function in some brain areas during episodes of depression.
- Changes in some of the brain chemical messenger systems occur in some people with depression. In particular, reductions in levels of two messengers called serotonin and noradrenaline seem to occur.
- Stressful events in early life can increase the risk of later depression. Loss of a parent before age 18 may increase risk of later depression, as may other traumatic events such as childhood abuse (physical, sexual, emotional).
- Stressful life events or situations such as divorce, social isolation or loss of a job can precipitate episodes of depression.
- There are no factors which are seen in all people with depression – these things apply to some but not all.

The stress-vulnerability model suggests that these different factors together make a person more vulnerable to developing depression. Stress then acts to trigger episodes of illness. If your vulnerability is high, then the stress of daily living may be overwhelming and you become depressed. With lower vulnerability, higher levels of stress can be tolerated before triggering a depressive episode.

People with depression often believe they developed a mental illness because things have gone wrong in their lives - it could be poverty, abandonment, sexual or physical abuse, being in an unhappy family or whanau, feeling alienated from society or not living up to people's expectations. Other people with depression cannot so easily find things that have gone wrong in their lives. They may agree with the view that their depression is genetic or biological in origin. A lot of people believe it is due to a combination of these things. Sometimes people think their mental illness is a punishment for their moral or spiritual failure. It's important to remember that it is not your fault you have depression.

Families and whanau, especially parents, can worry that they caused their child's depression. Sometimes they feel blamed by mental health professionals which can be very distressing for them. Most families and whanau want the best for their relative. It is important for them to understand what factors have contributed to their relative's problem and to be able to discuss their own feelings about this without feeling guilty or blamed.

Living with Depression

Consumer views¹

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

Discrimination and stigma

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

Support and information

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

Using services

Many people with depression, sooner or later, go to see their GP or a counsellor or are referred to mental health services. If you fear you might harm or kill yourself it is vital that you seek help immediately. Sometimes it is hard for people to seek help because they feel ashamed and want to hide their distress. Acknowledging they have a mental health problem and need help can be very scary. People with depression often say the best services are ones where they are listened to, treated as equals and are given support or treatment that works for them. Otherwise, the service is unlikely to meet their needs.

¹ A consumer is a person who experiences or has experienced mental illness, and who uses or has used mental health services. The term also refers to service user, survivor, patient, resident, and client.

Recovery

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

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

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

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

Important strategies for recovery

People with depression have found the following strategies to be useful and important.

- Learn about depression and the treatment options. Have access to information to help make sense of what has happened. Health professionals and others involved in assisting recovery should provide information in a way and at a pace that is comfortable for you.
- Take as active a part as possible in decisions about treatment and support. Being involved in decisions is the best way to ensure that you can make informed choices about what is best for you.
- Get treatment and support from people you trust, who expect the best for you but are able to accept how you are at any time.
- Have the continuing support of family or whanau and friends, who know about the condition and understand what they can do to support your recovery. Involve family, whanau, friends or other important people (e.g. kaumatua or church minister) in your treatment team if you wish.
- Have the opportunity to receive support from culturally appropriate support groups, organisations or advocates (trained supporters) who can help you to recover and stay well.
- Have the opportunity to recuperate – have time out and relax, but also feel encouraged to become more active as you are able.
- Take steps to improve your general health. Some daily exercise, a healthy diet, plenty of fluids, and relaxation can all be important in aiding recovery and keeping well.
- Sleep regular hours. Go to bed and get up at around the same time, and avoid sleeping during the day. Avoid drinks containing caffeine (tea, coffee, cola, so-called 'smart' drinks, etc.). If you can't sleep at night get up after 30 minutes and do something relaxing. Try to avoid worrying about not sleeping.

- Be realistic in what you expect of yourself, especially during an episode. When things seem too hard, take them on one step at a time.
- Do something enjoyable each day, and try to focus on positive thoughts and memories.
- Find the ways of coping that work best for you. These are different for each person, but are a critical first step on the path to recovery.
- Have the opportunity to make sure that your physical and spiritual needs are met.
- Become familiar with their early warning sign of relapse, and be part of developing a plan to maintain wellness. Health professionals involved in your care will help with this.
- Avoid or really cut down the use of alcohol and illegal drugs, as these may worsen the condition and increase the chances of relapse.
- Talk to your health professionals if you are considering stopping treatment and work together with them to find some compromise that will ensure continuing wellness but address your concerns about the treatment. It is very important that any decision to stop medication is made with the input of your doctor and ideally, your whole treatment team.

Family and whanau views

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

Discrimination and stigma

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

Support and information

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

and whanau need information on the person's condition, their options for treatment and their rights

Experiences with services

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

Recovery

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

Important strategies to support recovery

Family, whanau and close friends of people with depression have found the following strategies to be useful and important.

- Learn about the disorder, its treatment, and what you can do to assist recovery.
- See yourself as part of the treatment team and, in particular, learn about the signs of relapse and, with the help of clinical staff, agree with the person how you can help them stay well.
- Understand the symptoms for what they are. Try not to take them personally or see the person as being difficult.
- Help the person to recognise stress and find ways of coping. This may include helping to solve problems that worry them.
- Encourage the person to be more active, but without pushing or criticising them, as this may make things worse. Accepting the person as they are and having realistic expectations for them is very important.
- Help and encourage the person to lead a healthier life, including exercise, trying to do enjoyable activities and seeing the positive side of things.
- Encourage the person who has been unwell to continue treatment, and to avoid alcohol and drug abuse.
- Find ways of getting time out for yourself and feeling okay about this. Caring for a family or whanau member with depression can be stressful. It is important to maintain your own wellbeing.

Treatment of Depression

Summary of treatment options

Treatment of depression involves a number of important components, each of which can be tailored to the needs of the individual and the stage of the condition. The main components are:

Medication

The mainstay of this aspect of treatment is antidepressant medication. These are usually prescribed in the treatment of all depression. Other medicines may be used according to individual need and symptoms, especially during episodes of depression. Finding the right medication can be a matter of trial and error – there is no way to predict which medication will be effective and tolerated (have fewer troublesome side effects) by any one person. If you are prescribed medication you are entitled to know the names of the medicines; what symptoms they are supposed to treat; how long it will be before they take effect; how long you will have to take them for and what their side-effects (short and long-term) are.

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

Psychosocial treatments

Psychosocial treatments are non-medical treatments which address the person's thinking, behaviour, relationships and environment, including their culture. They may include problem solving which is a treatment as effective as antidepressants for milder forms of depression. Psychoeducation is a process where the person and their family or whanau have the opportunity to learn about depression and about how to work together to communicate effectively and deal with stress. This is particularly used for moderate or severe depression, where it has been shown to contribute to improved outcome. Psychological therapies (often referred to as therapy or psychotherapy) involve a trained professional who uses clinically researched techniques, usually talking therapies, to assess and help people understand what has happened to them and to make positive changes in their lives. They may involve the use of specific therapies such as cognitive-behavioural therapy (CBT), which largely focuses on overcoming unhelpful beliefs, or Interpersonal Therapy (ITP), which focuses on exploring relationships. Both of these have been shown to be slightly more effective in treating mild to moderate depression than antidepressants. Used with medication, there is often an improved effect. Counselling may include some techniques used in psychological therapies, but is mainly based on supportive listening, practical problem solving and information giving.

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

Complementary therapies

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

Medication

Antidepressants

Antidepressants are the main medications used to treat depression. Antidepressants are not addictive. Apart from the risk of the depression recurring, there are usually no withdrawal effects, although if stopped suddenly there may be mild symptoms such as feeling shaky.

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

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

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

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

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

After recovery from a first episode of depression it is recommended that the person stay on medication for six to 12 months, as there is a high risk of symptoms returning if it is stopped sooner than this. With subsequent episodes of depression, the risk of further episodes increases dramatically. It is now recommended that after a second episode, medication be continued for two to three years. If a person experiences more than two episodes they may need to consider long term medication.

All of these medicines are available in tablet or capsule form. Fluoxetine and nortryptiline are also available as a syrup.

Mood stabilising medications - lithium carbonate

Lithium carbonate (Lithicarb and Priadel) is mainly used to treat bipolar affective disorder (manic depression). However, in depression which fails to improve with antidepressants and psychological treatments, it is sometimes effective when given with antidepressants. Because the difference between beneficial and toxic levels of lithium is small, blood tests must be done to ensure the right dose.

If the blood level of lithium becomes too high immediate side effects are nausea, diarrhoea, shaking, thirst, and a metallic taste in the mouth. This may progress to the person seeming drunk, with slurred speech and staggering. If these occur it is very important to contact your doctor.

For those on long-term lithium, weight gain (average three to four kilos) can occur. Thyroid and kidney problems are other uncommon delayed effects. Three to six-monthly blood tests are needed to detect these early before problems occur.

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

For more information about mood stabilisers refer to the medication section of the article on bipolar affective disorder.

Benzodiazepines

Benzodiazepines (the valium type of medications) are used to treat anxiety symptoms which often accompany depression and sleep problems. They increase the activity of a chemical in the brain called GABA (gamma amino butyric acid) which regulates alertness. This lessens anxiety, induces sleepiness, and makes the muscles relax. Benzodiazepines work almost immediately and have few side effects. The main side effect of drowsiness or fatigue may be useful during the acute phase. This usually wears off.

Benzodiazepines are known to be addictive so they are usually only prescribed for two weeks at a time. Stopping them needs to be done gradually. Sudden stopping may produce withdrawal symptoms such as anxiety, insomnia, headaches, nausea and dizziness and, occasionally, may induce epileptic seizures. People with epilepsy must be careful as withdrawal can also make seizures more likely.

Benzodiazepines are not advised in pregnancy especially near birth, as they can affect the baby and some of them get into breast milk.

Benzodiazepines are safe with almost all other medicines. Because they magnify the effects of alcohol, it should be avoided.

Antipsychotics

Antipsychotic medications are used to treat severe depression where symptoms of psychosis (loss of touch with reality) are present. In this case antidepressants alone are

ineffective. Usually, antipsychotics are prescribed first, then antidepressants once the psychotic symptoms begin to decrease.

Antipsychotics work by blocking the effect of a brain chemical messenger called dopamine. Overactivity of dopamine is thought to be part of the problem causing psychotic symptoms. Beneficial effects often have gradual onset over one week or more. In low doses, these medicines are also effective in reducing symptoms of anxiety. This effect is usually immediate. Antipsychotics are not addictive. The high potency antipsychotics (see below) are generally considered safe during pregnancy.

There is a considerable range of these medicines, all of which share different side effects, though in low doses many people will have no or very few side effects. The traditional (older) antipsychotics are either low-potency or high-potency, according to the size of dose required to give benefit. The low-potency medications include chlorpromazine (Largactil) and thioridazine (Melleril). They mainly cause sedation (tiredness), dry mouth, constipation, dizziness, and various sexual function problems. It has recently been found that thioridazine (Melleril) is associated with a risk of heart rhythm abnormalities in some people. It is recommended that anyone taking thioridazine has an electrocardiogram (ECG) and blood tests to check this.

The high potency drugs include haloperidol (Serenace), thiothixene (Thixit), trifluoperazine (Stelazine) and zuclopenthixol (Clopixol). They mainly cause muscle side effects such as shaking, muscle spasm, and restlessness. These muscle side effects can be blocked by the use of side effect medications such as benztropine (Cogentin) and procyclidine (Kemadrin).

More recently the atypical (or new) antipsychotic drugs have become available – they cause fewer side effects but, because they are much more expensive, their use has until recently been limited to people with illnesses such as schizophrenia who must take them long-term. However, they are also prescribed where people have severe side effects with the traditional antipsychotic drugs. The atypical drugs currently available in New Zealand are Risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel) and clozapine (Clozaril). (For further information on antipsychotic medications refer to the medication section of the article on schizophrenia).

Medicine interactions

Most psychiatric medicines tend to react with each other when taken in combination. Their sedative effect in particular may make you feel sleepy. Your doctor will, where possible, limit the number of medications prescribed.

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

Psychosocial treatments

Problem solving

This therapy involves teaching the person to use their own skills and resources to cope with problems and worries. It is as effective as antidepressants in milder forms of depression, and is usually given over six to eight weekly sessions. It has the advantage of requiring little training, and is readily able to be used in a general practice setting

(which is where most people with depression are seen).

The steps in problem solving are:

- identify and clarify the problem
- set clear achievable goals
- brainstorm solutions
- select the preferred option
- evaluate progress in putting the chosen option into action.

Psychoeducation

Psychoeducation is a process where a health professional works with people with severe forms of depression, and with their families and whanau, to provide information about the illness, its treatment, and how to support the steps to recovery. Central to this approach is that family or whanau, along with the person with depression, are critical members of the treatment team. Together they identify ways of dealing with symptoms, difficult to understand behaviour and stress. The early signs which indicate a possible relapse are identified and a plan of early response developed. There is also attention to the kinds of support that everyone needs, and how to get this.

Psychological therapies and counselling

Psychological therapies have been found to be effective in the treatment of depression. Often they will be recommended in addition to medication, or as an alternative to medication in the case of less severe depression or where a person does not choose medication. Therapy may be held on a one-to-one basis, include partners or families and whanau for some sessions, or be held in a group.

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

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

Treatment for severe depression may be available free of charge at a community mental health service. At a number of community service agencies charges are based on your ability to pay. Private therapists' fees may range from \$60 to \$200 per session but many also have a sliding scale of fees.

Cognitive-behavioural therapy (CBT)

The basic theory of cognitive-behavioural therapy is that our thoughts and beliefs influence our feelings and behaviour. The focus of treatment is on identifying specific negative thoughts and actions, and developing ways to change these. The cognitive part of the therapy helps the person to identify and challenge these thoughts. They may, for example, say that they are always sad. With encouragement from the therapist and careful exploration of their thoughts, they come to see that in reality it is only certain situations which make them sad. At other times they may experience some pleasure. The therapist may then encourage them into developing behavioural strategies to help

lift their mood, such as going for a short walk or doing some small thing which they may once have enjoyed. These activities are often in the form of small homework tasks. CBT also incorporates other techniques useful in helping depression, such as teaching the person relaxation skills, stress management and problem solving (as outlined above).

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

Interpersonal therapy (IPT)

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

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

Side Effects of Medications

Antidepressant medications – tricyclics

<u>Generic name</u>	<u>Trade name</u>	<u>Common side effects of tricyclic antidepressants</u>
Amitriptyline	Amitrip	<p>Drowsiness and loss of energy. This can be useful if sleep is a problem. In this case the medicine is taken at night.</p> <p>Dizziness especially with standing up from lying or sitting. Care is needed especially in older people as this can lead to falls.</p> <p>Dry mouth. Water and sugar-free gum are good ways to reduce this.</p> <p>Constipation. Plenty of liquids, fruit and vegetables can reduce this.</p> <p>Blurred vision. This may mean reduction or change of drug.</p> <p>Trouble urinating. This is mainly a problem for older men.</p> <p>Increased sweating. While many people notice this most are not troubled by it.</p> <p>Weight gain. Exercise and a healthy diet are the best ways to minimise this.</p> <p>Sexual problems such as impotence, reduced sex drive, or lack of orgasm.</p> <p><u>Serious side effects of tricyclic antidepressants</u></p> <p>Heart problems. This is only in people who already have heart problems, or are elderly. Some of this group of medications are actually safer for people with heart problems.</p> <p>Psychosis symptoms, or worsening of symptoms of psychosis. This is rare.</p> <p>Overdose. These drugs are very dangerous in overdose, due to their effects on the heart.</p>
“	Tryptanol	
Amoxapine	Asendin	
Clomipramine.....	Anafranil	
“	Clopress	
Desipramine	Pertofran	
Dothiepin.....	Prothiaden	
“	Dopress	
Doxepin	Anten	
Imipramine	Tofranil	
Maprotiline	Ludiomil	
Mianserin.....	Tolvon	
Nortriptyline	Allegron	
“	Norpress	
Trimipramine.....	Surmontil	
“	Tripress	

Antidepressant medications – RIMAs

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

Antidepressant medications - SSRIs

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

Antidepressant medications - SSRI-like drugs

<u>Generic name</u>	<u>Trade name</u>	<u>Common side effects of SSRI-like drugs</u>
Nefazodone.....	Serzone	<p>Nausea, headache and dry mouth may wear off after initial effect.</p> <p>Light-headedness or dizziness may occur.</p> <p>Blurred or double vision can be a problem.</p> <p>Sexual problems are usually less frequent than with the SSRIs.</p> <p>Trouble sleeping and abnormal dreams, if persisting may require medication to be changed.</p> <p>Sedation and tiredness may be experienced by others.</p> <p>Weight loss may occur in some people.</p> <p>Sweating is occasionally noticed but not usually a problem.</p>
Venlafaxine	Effexor	

Anxiolytics - benzodiazepines

<u>Generic name</u>	<u>Trade name</u>	<u>Common side effects of benzodiazepines</u>
Diazepam.....	Valium	<p>Drowsiness is particularly dangerous for people who operate machinery or while driving vehicles.</p> <p>Muscle relaxation can be a risk for older people whose muscles may be weak and thereby increase their risk of falling.</p> <p>Confusion, particularly with older people .</p> <p>Breathing difficulties. Benzodiazepines can reduce breathing a little. Those people with severe breathing problems need to be careful.</p> <p>Dependency and withdrawal problems - see discussion in text.</p>
“	ProPam Tab	
“	Stesolid Rectal Tube	
“	Diazemuls injection	
Clonazepam.....	Rivotril	
Lorazepam.....	Ativan	
“	Lorapam	
Alprazolam	Xanax	

Complementary Therapies

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

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

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

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

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

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

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

Legislation

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

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

Recommended publication

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

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

Ministry of Health

133 Molesworth Street
PO Box 5013
WELLINGTON

Ph 04 496 2000
Fax 04 496 2340
Email EmailMOH@moh.govt.nz
Web www.moh.govt.nz

Mental Health Commission

PO Box 12479
Thorndon
WELLINGTON

Ph 04 474 8900
Fax 04 474 8901
Email info@mhc.govt.nz
Web www.mhc.govt.nz

Department for Courts

PO Box 2750
WELLINGTON

Ph 04 918 8800
Fax 04 918 8820
Email family@courts.govt.nz
Web www.courts.govt.nz/family

More contact details for government agencies are listed in the following sections.

The Health and Disability Commissioner Act 1994

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

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

The Act's objective is achieved through

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

Code of Health and Disability Services Consumers' Rights

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

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

The Health and Disability Commissioner

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

AUCKLAND
Level 10, Tower Centre
45 Queen Street
PO Box 1791
Auckland

Ph 09 373 1060
Fax 09 373 1061

WELLINGTON
Level 13, Vogel Building
Aitken Street
PO Box 12 299
Wellington

Ph 04 494 7900
Fax 04 494 7901

The Human Rights Act 1993

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

Human Rights Commissioner

Freephone 0800 496 877

TTY (teletypewriter) access number 0800 150 111

Email infoline@hrc.co.nz

Web www.hrc.co.nz

AUCKLAND

4th Floor, Tower Centre
Corner Queen & Custom Streets
PO Box 6751
Auckland

Ph 09 309 0874

Fax 09 377 3593

WELLINGTON

Level 8, Vogel Building
8 Aitken Street
PO Box 12 411, Thorndon
Wellington

Ph 04 473 9981

Fax 04 471 0858

CHRISTCHURCH

7th Floor, State Insurance Building
116 Worcester Street
PO Box 1578
Christchurch

Ph 03 379 2015

Fax 03 379 2019

The Privacy Act 1993

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

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

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

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

The Privacy Commissioner.

Freephone 0800 803 909

Office of the Privacy Commissioner

PO Box 466
AUCKLAND

Ph 09 302 8655

Email privacy@iprolink.co.nz (Auckland)
privacy@actrix.gen.nz (Wellington)

Web www.privacy.org.nz

Further information

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

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

The Mental Health (Compulsory Assessment and Treatment) Act 1992

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

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

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

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

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

Further information

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

The Schizophrenia Fellowship (SF)

Freephone 0800 500 363

National Office

PO Box 593

Christchurch

Ph 03 366 1909

Fax 03 379 2322

Email office@sfnat.org.nz

Web www.sfnat.org.nz

Look in your telephone directory for the local Schizophrenia Fellowship.

The Children, Young Persons and Their Families Act 1989

This Act applies in two situations.

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

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

Formal options available through this Act are:

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

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

For more information, it may be helpful to contact:

The Office of the Commissioner for Children

PO Box 5610
WELLINGTON

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

Youthlaw Tino Rangatiratanga Taitamariki

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

PO Box 7657
Wellesley Street
AUCKLAND

Ph 09 309 6967
Fax 09 307 5243
Email youthlaw@ihug.co.nz
Web www.youthlaw.co.nz

The Criminal Justice Act 1985

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

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

The Protection of Personal Property Rights Act 1988

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

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

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

Further Information

Support groups and organisations

Lifeline

P O Box 74010
Market Road
AUCKLAND

Freephone 0800 111 777

Ph 09 522 2999, for 24-hour counselling service.

Ph 09 524 3080 (office)

To find a local number, look in the phone book for Lifeline or Samaritans.

Schizophrenia Fellowship NZ Inc. (SF)

SF is a national organisation with branches through out New Zealand. It provides support, information and education for families and individuals affected by mental illness.

P O Box 593
CHRISTCHURCH

Freephone 0800 500 363

Ph 03 366 1909

Fax 03 379 2322

Email office@sfnat.org.nz

Web www.sfnat.org.nz

GROW

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

AUCKLAND

Ph 09 846 6869

Email national@grow.org.nz

CHRISTCHURCH

Ph 03 366 5890

DUNEDIN

Ph 03 477 2871

Email growdunedin@actrix.co.nz

Depressive Disorders Support Group (Waikato)

The group focuses on recovery and maintaining wellness through the principles of peer support and self help.

Centre 401, Tristram House
306 Tristram Street
P O Box 1183
HAMILTON

Ph 07 838 0199
Fax 07 838 3250
Email psych-survivors@xtra.co.nz

Depression Support Network

A community organisation developed, led and managed by people whose lives have been affected by depression.

2nd Floor – Securities House
221 Gloucester Street
P O Box 13167
CHRISTCHURCH

Ph 03 366 8083
Fax 03 365 5345
Email depression.net@xtra.co.nz

Websites

The Mental Health Foundation's website has information about the mental health sector and mental health promotion, news of upcoming conferences both here and overseas, links to other sites of interest and the Foundation's on-line bookstore. It also contains the full text of all the MHINZ booklets which can be downloaded as pdf or Word files.

www.mentalhealth.org.nz

DepressioNet
www.depressionet.com.au

Wing of Madness: A Depression Guide
www.wingofmadness.com/index.htm

Beyond Blue: The National Depression Initiative
www.beyondblue.org.au

Depression @lliance
<http://www.depressionalliance.org>

Books

Family Education in Mental Illness by Agnes B Hatfield. Guilford Press, 1990.

Feeling Good: The New Mood Therapy by David D Burns & Aaron T Beck. Avon, 1999.

I Can See Tomorrow: A Guide to Living with Depression by Patricia Owen. Hazelden, 1995.

Mind Over Mood: Change How You Feel by Changing the Way You Think by Dennis Greenberger and Christine A. Padesky. Guilford Press, 1995.

Prozac and the New Antidepressants by William Appleton. Plume, 2000.

Queer Blues: The Lesbian and Gay Guide to Overcoming Depression by K. Hardin, B. Berzon and M Hall. New Harbinger, 2001.

The Depression Workbook: A Guide for Living with Depression and Manic Depression by Mary Ellen Copeland. New Harbinger, 1992.

The Feeling Good Handbook by David Burns. New York: Plume, 1999.

Thoughts and Feelings Taking Control of your Moods and your Life by M McKay, M Davis & P Fanning. New Harbinger, 1997.

Sharing the Load: What to do When Someone You Love is Depressed by Gwendoline Smith. Random House, 1996.

Undoing Depression: What Therapy Doesn't Teach You and Medication won't Give You by Richard O'Connor. Berkley Publishing Group 1999.

Beyond Negative Thinking: Breaking the Cycle of Depressing and Anxious Thoughts by Joseph T. Martorano and John P. Kildahl. Plenum 1989.

Mental Health Foundation Resource & Information Centre

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

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

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

Mental Health Foundation of New Zealand

PO Box 10051
Dominion Road
Auckland

81 New North Road
Eden Terrace
Auckland

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

Titles in the MHINZ series of booklets

<i>Attention Deficit / Hyperactivity Disorder</i>	<i>Dementia</i>
<i>Alcohol Problems</i>	<i>Depression</i>
<i>Anorexia Nervosa</i>	<i>Depression in Children and Young Adults</i>
<i>Attachment Disorder</i>	<i>Obsessive-Compulsive Disorder</i>
<i>Autism</i>	<i>Panic Disorder</i>
<i>Bipolar Affective Disorder</i>	<i>Personality Disorders</i>
<i>Brief Psychotic Disorder</i>	<i>Phobias</i>
<i>Bulimia Nervosa</i>	<i>Postnatal Depression & Psychosis</i>
<i>Cannabis Problems</i>	<i>Problems with Tranquilliser Use</i>
<i>Conduct Disorders</i>	<i>Schizophrenia</i>

Complementary Therapies in Mental Health
Delusional Disorders

Separation Anxiety Disorder
Solvent and Inhalant Problems
Tourette Disorder