



Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

Medications and You





Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

Medications and You

Mood Disorders Society of Canada is pleased to present Medications and You, as part of our public educational resource series.

We know that one in five Canadians will have a mental illness or issue each year. Often, the first step is a discussion with a family physician or other health professional about the challenges that you are experiencing. When you or a family member/ friend experience mental health issues, often medications are part of the recovery process. Through this book, it is our hope we can assist by providing you with easy to understand information on medications.

This important resource could not have been developed without the dedication from Dr. Barbara Everett in assisting in the researching and writing of this handbook and to members of our advisory panel, with special appreciation to Dr. Alexandra Heber and Dr. Jeffrey Habert, along with all those who have contributed their time and effort to this project.

Mental illness affects all Canadians. The overarching message that Mood Disorders Society of Canada wants to convey in all its work is that recovery from mental illness is possible.

Dave Gallson
National Executive Director
Mood Disorders Society of Canada

Additional hardcopies of this handbook or any other of our other publications can be ordered by going to our website at www.mdsc.ca and sending us an email request by clicking on "contact us".



Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

TABLE OF CONTENTS

| | |
|--|----|
| Introduction | 1 |
| Chapter 1 – Diagnosis | 2 |
| Asking for help | 2 |
| Preparing for your appointment | 2 |
| Chapter 2 – Medications and You | 5 |
| Anti-depressants | 5 |
| Other useful medications | 7 |
| More to know about medication | 8 |
| Some general pharmaceutical terms | 9 |
| Chapter 3 – Major depressive disorders | 10 |
| Types of depression | 11 |
| Referral to a psychiatrist | 12 |
| Medication | 12 |
| Psychotherapy | 12 |
| Treatment resistant depression | 14 |
| Chapter 4 – Anxiety disorders | 15 |
| Types of anxiety | 15 |
| Medication | 16 |
| Psychotherapy | 16 |
| Chapter 5 – Bipolar disorder | 17 |
| Different types of bipolar disorder | 18 |
| Medication | 18 |
| Psychotherapy | 18 |
| Chapter 6 – Post-traumatic stress disorder (PTSD) | 19 |
| Symptoms | 20 |
| Medication | 22 |
| Psychotherapy particularly for PTSD | 23 |
| Peer support for PTSD | 24 |
| Chapter 7 – Ongoing support strategies | 25 |
| Some places to start | 25 |
| Chapter 8 – Recovery and relapse prevention | 28 |
| Recovery | 28 |
| Relapse prevention | 29 |
| A selection of online resources | 30 |



Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada



Introduction

People experiencing mental illness have to contend, not only with the illness, but with a complex journey through the medical and psychiatric systems. Most will be prescribed medications to help stabilize their symptoms so that they can take on the many challenges of getting well and staying well. But which medications? How are they expected to help? As people leave the doctor's office with their prescription, they can feel on their own. This publication can accompany them. It takes them from diagnosis, to medication, to therapy and to discovering supports and relapse prevention strategies. It concentrates on four mental illnesses; major depressive disorder, anxiety disorders, bipolar disorder and post-traumatic stress disorder (PTSD).

Medications and You is intended to ease your journey with information and encouragement.



Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

Chapter 1 – Diagnosis

Most people struggling with the symptoms of a mental illness know there is something wrong. Many try to power through, telling themselves that they will get over it. Some are right. They do get over it – but only those with the mildest of symptoms. Most struggle until they reach a day when they know they need help. Sometimes people have let things slide to such an extent that their symptoms have overwhelmed all aspects of their lives. Getting early diagnosis and treatment is by far and away preferable,¹ but sometimes, it just doesn't happen.



Asking for help

You are not coping and you know it – people around you know it. You need help.

The majority of people turn to their family doctor as the first step, or if they don't have a family doctor, their local Emergency Department. The goal is find out what's wrong – and to get a diagnosis.

Receiving a diagnosis of a mental illness is never a happy event but it can be a relief to finally have a name for what you've been experiencing.

A diagnosis is the foundation for determining treatment. It answers the question: What do I do now?

Preparing for your appointment

There is a lot your doctor is going to want to know to arrive at an accurate diagnosis. It will be helpful if you write down in advance a brief description of:

¹ Habert, J. et al (2016). Functional recovery in major depressive disorder: Focus on early optimized treatment. Primary Care Companion, CNS Disorders. Vol 18 (5), doi:4088/PCC.15r01926.



- the symptoms you are experiencing,
- whether or not you have other illnesses, including past or present substance abuse, and
- what medications you are on, including over-the-counter supplements.

Symptoms

The following are the areas of your life and current experience that are relevant:

- Mood
- Thinking
- Behaviour
- Relationships
- Day-to-day functioning and stresses
- Sleeping and eating patterns

If you can, take someone with you to your first appointment. It is valuable to have a second set of eyes and ears with you – to listen and to take notes. With your permission, they may also provide observations because, in all likelihood, they have noticed things about your symptoms and behaviours that you may not have noticed yourself.

As a courtesy, ask your doctor if you can bring your friend into the interview with you. Some doctors may prefer to see you, for at least part of the visit, on your own.

This is likely to be a lengthy discussion and your doctor won't have the time to go through everything in one appointment. Ask for another appointment (as soon as possible) to finish this discussion. Your doctor needs to understand thoroughly what's been going on.

Here are some questions for you to consider asking. Choose two or three of the most pertinent questions at a time.

- What do you think this is?
- What are your treatment recommendations?
- Do people get better? How long does it take?
- What medication(s) do you recommend? What are the possible side effects? How long do they take to work? What do we do if they aren't working? What is the best medication for my needs?
- What will I notice if the medication is working? How long should I wait before I conclude that it is not working and we need to try something else? (Note: two to four weeks is reasonable.)
- How long will I need to take this medication?
- What about my job? Will the medication affect my ability to work? Should I take time off?
- Will you refer me to a psychiatrist?
- Where can I go for more information?
- What can I do to help myself?
- When should I come back for my next appointment? Note that it is optimal for your doctor to see you every two to four weeks until you are feeling better.

You've done it. You've taken the first step.





Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

Chapter 2 – Medications and You

Medications for depression, anxiety, bipolar disorder and post-traumatic stress disorder have brand names and corresponding chemical names (both often listed on your prescription bottle). They can be used interchangeably, confusing patients.

In addition, medications prescribed for one disorder can be helpful for other disorders and vice versa. Therefore, there can be a considerable overlap in discussing medication whether you have been diagnosed with depression, anxiety, bipolar disorder or post-traumatic stress disorder.

Note: The one exception is lithium which is prescribed exclusively for bipolar disorder.

This chapter will outline the many medication options available for all disorders discussed in this publication. It is intended as a reference so that you will have familiarity with what's available. Of course, you and your doctor will be making the final decision on which medication (or combination of medications) is best for you.

Other chapters in this publication will refer you back to this chapter as the various topics unfold.

Anti-depressants

Anti-depressants have been available for a number of decades and have evolved and improved. The Canadian Network for Mood and Anxiety Treatments (CANMAT), a partnership among researchers, psychiatrists and other clinicians, has published detailed depression treatment guidelines for professionals. The guidelines provide a review of available research on depression and present recommendations for anti-depressants.² They categorize medications as first, second and third line, according to effectiveness as demonstrated through evaluation research.

The following anti-depressants are from CANMAT's *first and second line listings*.

There are more anti-depressants on the market than these and your physician may recommend something else for you. That's OK – as long as it works for you.

² Kennedy, S. et al (2016). Canadian Network for Mood and Anxiety Treatments (CANMAT). Clinical guidelines for the management of major depressive disorders in adults. Section 3 Pharmacological treatments. Canadian Journal of Psychiatry, Vol 61 (9). Available through subscription to the Journal.



First line

(strongest evaluation research results)

| Brand name | Chemical name |
|-------------------|----------------------|
| Valdoxan | agomelatine |
| Wellbutrin | bupropion |
| Celexa | citalopram |
| Pristiq | desvenlafaxine |
| Cymbalta | duloxetine |
| Cipralex | escitalopram |
| Prozac | fluoxetine |
| Luvox | fluvoxamine |
| Tolvon | mianserin |
| Ixel | milnacipran |
| Remeron | mirtazapine |
| Paxil | paroxetine |
| Zoloft | sertraline |
| Effexor | venlafaxine |
| Trintellix | vortioxetine |

Second line

(strong evaluation research results)

| Brand name | Chemical name |
|----------------------|------------------------|
| Fetzima ³ | levomilnacipran |
| Manerix | moclobemide |
| Seroquel | quetapine |
| Emsam | selegiline transdermal |
| Desyrel | trazodone |
| Viibryd | vilazodone |

³ This is a CANMAT second line recommendation but included on advice of a member of MDSC's Expert Panel.

Other useful medications

1. Atypical anti-psychotics

Atypical anti-psychotics are called second generation anti-psychotics because they have fewer side effects than previous ones - but some remain so it is wise to talk with your doctor before choosing this course of action. With mental illness, they are most often used in combination with an anti-depressant to boost its effect. Examples are:⁴

| Brand name | Chemical name |
|------------|---------------|
|------------|---------------|

| | |
|-----------|--------------|
| Abilify | aripiprazole |
| Seroquel | quetiapine |
| Risperdal | risperidone |
| Latuda | lurasidone |
| Zyprexa | olanzapine |

2. Anti-convulsants⁵

In the case of depression, anxiety, bipolar disorder or post-traumatic stress disorder, anti-convulsants can be prescribed, not for their anti-convulsant properties, but as *mood stabilizers*

| Brand name | Chemical name |
|------------|---------------|
|------------|---------------|

| | |
|-----------|------------|
| Lyrica | pregabalin |
| Neurontin | gabapentin |

An anti-convulsant especially recommended for PTSD is:

| Brand name | Chemical name |
|------------|---------------|
|------------|---------------|

| | |
|---------|------------|
| Topamax | topiramate |
|---------|------------|

3. Benzodiazepines (tranquilizers)

Tranquilizers are prescribed with caution. People who are taking them find that they do, indeed, provide calm and peaceful feelings but their bodies can adjust to the initial dosage to the point where they start to be ineffective, encouraging higher and higher amounts for the same calming effect. This is known as habituation. The very serious downside of habituation is addiction. Your physician or psychiatrist will monitor your usage closely.⁶

| Brand name | Chemical name |
|------------|---------------|
|------------|---------------|

| | |
|--------|------------|
| Valium | diazepam |
| Ativan | lorazepam |
| Xanax | alprazolam |

⁴ ibid

⁵ ibid

More to know about medication

Additional factors in making a prescribing decision

Whenever your physician or psychiatrist is prescribing medication, they will take the following into account (as well as your diagnosis):

- Age
- Weight
- Pregnant or nursing
- Other illnesses and/or allergies
- Other drugs you are taking

The role of your pharmacist

Pharmacies often have private rooms for confidential discussions. The pharmacist usually has information sheets (in plain language) or can recommend Internet sites for you to visit. They may also be able to take more time with you than your physician. If this is your regular pharmacist, they will have all your medications on record. They can advise you about possible interactions, which you can then discuss with your physician.

Other things to know

Contra-indication: Given your health circumstances, other illnesses, allergies or medications you already take, you should not be prescribed this specific drug.

Interactions: A drug, when taken with a certain other drug, can affect you in negative ways.

Side effects: Most medications are accompanied by side effects – either commonly experienced, experienced by some only, or rarely experienced. Your physician will educate you about them. If you experience side effects, document them and report them to your doctor or psychiatrist. You may want to choose another medication.

Special note: Common side effects for anti-depressants are nausea and headaches, and a lowered sex drive. Some also lead to weight gain – all of which can be managed but they are nonetheless troubling for people. The newer of anti-depressants have reduced side effects.

Adverse reactions: An adverse reaction is a rare, or even life-threatening result for some people, discovered after a medication has come to market. Pharmaceutical companies are required by regulation to report adverse reactions to Health Canada and your doctor and psychiatrist should do the same. If you believe you are having an adverse reaction, contact your doctor immediately or go to the Emergency Department.



Some general pharmaceutical terms

Generics: When patent protection for a brand named drug expires, generic versions become available. Government and most employee drug benefits programs insist that pharmacists substitute generic versions for their brand named counterparts when filling your prescription. Generics are much less expensive than brand name medications. If you feel only the brand name drug is effective for you, your doctor or psychiatrist can direct the pharmacist not to substitute it for a generic. On the other hand, if you don't mind a generic (if you are paying out-of-pocket, they are the economical choice), your physician should tell your pharmacist that they must fill your prescription with the same generic every time.

Formularies: Provinces and Territories have formularies which list approved medications for people entitled to government paid drug benefits (for example, seniors, the disabled or people on welfare). Each Province or Territory can have a somewhat different formulary, making coverage uneven across the country. New drugs and rare drugs usually can't be found on formularies, meaning people have to pay out-of-pocket.

Learning about medication is an important step to restoring your health



Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

Chapter 3 – Major depressive disorder

People with major depression are not merely feeling down or blue. Sadness and despondency have overwhelmed almost all aspects of their lives.

Your doctor will ask how long you've been feeling this way, along with the specific questions listed in Chapter 1. Formally, the diagnostic criterion is "more than two weeks" but practically, many people struggle much longer before they ask for help.

Symptoms:⁷

- Persistent deep sadness and feelings of worthlessness or guilt
- Irritability
- Muddy and slowed thinking, difficulty concentrating, remembering and making decisions
- Loss of interest in work, relationships and leisure activities
- Slowed movement and talking along with low energy
- Troubling alterations in sleep patterns; difficulty getting to sleep, staying asleep, waking up too early or sleeping too much
- Noticeable weight gain or weight loss
- Thoughts of suicide or, most frightening, suicide attempts

Sometimes, people experience physical pain in their body and this discomfort is what brings them to their doctor. Over time, however, despite real suffering, there seems to be no identifiable cause for the pain. This is a signal that what you may really be dealing with is depression.⁸

People with other illnesses such as cancer, heart disease, stroke, Parkinson's, Alzheimer's, and diabetes – as some examples – can also have depression. Conversely, people with depression are more likely to develop other diseases.⁹

⁷ Habert, J. et al (2016). Functional recovery in major depressive disorder: Focus on early optimized treatment. Primary Care Companion, CNS Disorders. Vol 18 (5), doi:4088/PCC.15r01926.

⁸ Mood Disorders Society of Canada. What is Depression. Available at: www.mdsc.ca

⁹ Habert, J. et al (2016). Functional recovery in major depressive disorder: Focus on early optimized treatment. Primary Care Companion, CNS Disorders. Vol 18 (5), doi:4088/PCC.15r01926.

Types of depression¹⁰

Major depressive disorder (MDD): Some people experience severe symptoms (as listed above) and these symptoms persist. They can recover with treatment but are at risk of a recurrence.

Persistent depressive disorder or dysthymia: This is a less debilitating form of depression where people continue to function but life is sad and grey. This can persist for years with people thinking that this is just the way life is.

Post-partum depression: Post-partum depression is much more serious than just the baby blues. Women with post-partum depression experience ongoing deep sadness, guilt, poor sleep (even when they have periods of quiet to themselves), irritability, excessive worry about the baby's health, and a lack of joy. In its most severe and rare form, post-partum depression can evolve into post-partum psychosis where both mother and child are at severe risk. Post-partum psychosis means that the mother's thinking has lost touch with reality. She may be hearing voices. She may even think that she and her baby would be better off dead. It cannot be stressed strongly enough that a mother with post-partum psychosis must get to the Emergency Department and see a doctor immediately.

Psychotic depression: Here, a person's depression is accompanied by false beliefs (delusions) and sometimes hallucinations (hearing voices). Neither are based in reality nor are they believable to others. Anyone who develops psychotic symptoms along with their depression should see a doctor immediately.

Seasonal affective disorder (SAD): This form of depression is thought to be triggered by the lack of light in winter. For some people, SAD is mild and requires no treatment. Others experience it in more severe forms. Treatment (medication and specialized light boxes that simulate sunshine) will help and, of course, the onset of spring usually provides relief.



¹⁰ ibid

Depression accompanied by anxiety

About 50% of people diagnosed with depression are also diagnosed with anxiety. And the reverse is also true; 50% of those diagnosed with anxiety are likely to experience a depression.¹¹

People with co-occurring anxiety and depression may have poorer responses to anti-depressant medication. They also report more severe symptoms and their lives may be affected more deeply.¹²

Referral to a psychiatrist

During the diagnostic process, your doctor may think it necessary to refer you to a psychiatrist for specialized help.

It is a reality that patients have to wait – sometimes a long time - for a consultation with a psychiatrist. Alternatively, some areas of Canada have no psychiatrists at all. The lack of specialized psychiatric help is a point of frustration for all.

Medication

Refer to Chapter 2.

Psychotherapy

Research has shown that medication combined with therapy obtains the best results for people with depression and also for people with anxiety, bipolar disorder and post-traumatic stress disorder (PTSD).

Note: Advocates in the mental health field have long been dismayed at the relative unavailability of publicly funded therapy. People who have the means can pay on the private market but even then, there are wait times.

All therapies described below are time-limited and goal-focused. You work with your therapist to identify the problems that are concerning you and together, you develop solutions. In other words, reflection and exploration are combined with skill development and action.

¹¹ Anxiety and Depression Association of America.

Available at: <https://www.adaa.org/about-adaa/press-room/facts-statistics>

¹² National Institute of Mental Health (NIMH). Co-occurring anxiety complicates treatment response for those with major depression. Available at: <https://www.nimh.nih.gov/news/science-news/2008/co-occurring-anxiety-complicates-treatment-response-for-those-with-major-depression.shtml>



Cognitive Behavioural Therapy (CBT): CBT therapists teach you how your emotions can affect your thinking and your behaviours. They also show you how it is a two-way street. Behaviours also affect thinking and emotions. By bringing these connections to your awareness and learning coping strategies, you become much more in control of these intertwined dimensions and you can interrupt or even prevent a downward spiral.

Mindfulness-based cognitive behavioural therapy: CBT is integrated with mindfulness meditation which enhances your ability to identify thoughts and feelings – and observe them dispassionately rather than reacting to them automatically. It creates an additional level of awareness of how unrecognized thoughts and feelings are impeding your recovery.

Interpersonal therapy: This form of therapy focuses on you and how you are dealing with the relationships and stressors in your life. The things life throws at you do not cause mental illness but, if unresolved, they can certainly interfere with your recovery.

Marital or family therapy: Your partner (or family members) attend sessions with you and together, you work on identifying problems and trying out solutions.

Group therapy: People come together based on a shared experience, in this case a particular diagnosis of mental illness. The therapist acts as a resource and a facilitator as group members share experiences, their first-hand knowledge and coping tips. Group therapy shows you, “You are not alone.” It is empowering to know there are others just like you.

Psycho-education: This is a time-limited group dedicated to educating you about your illness. The more you know about your situation, the better equipped you are to partner with your medical advisors, manage your medications and monitor the symptoms of your illness.



Treatment resistant depression¹³

If a number of medications have been tried over a period of time and you are not getting better – or you get better for a while but your depression returns, you are experiencing treatment resistant depression. Your psychiatrist can recommend additional medication combinations but they may also suggest neurostimulation such as electroconvulsive therapy (ECT) or repetitive transcranial stimulation (rTMS). Both have been studied and identified as effective.

Neurostimulation interventions

ECT: With ECT, patients receive a light sedative prior to treatment, so that they are asleep when the treatment occurs. ECT involves using a controlled electric current to induce a mild seizure in one area of the brain. ECT is usually used for people with severe depression that has not responded to medication. It is one of the most effective treatments available for major depressive disorder and treatment resistant depression.

rTMS: rTMS requires a magnetic generator (coil) to be placed near your head. It emits a small electric current called electromagnetic induction.

Special note: Some patients may be anxious about neurostimulation treatments. Don't hesitate to discuss your options with your psychiatrist so you feel that your decision is fully informed.

There is help. Recovery is possible.

¹³ Treatment resistant depression or TRD is not a formal diagnosis. Instead it is a clinical description of your situation.



Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

Chapter 4 – Anxiety disorders

Anxiety disorders are the most common mental illnesses. Approximately 12% of Canadians are affected in any given year.¹⁶ The good news is that anxiety is highly treatable.

Anxiety can be accompanied by depression or it can occur on its own.

Types of anxiety

Generalized anxiety disorder: People are anxious and worried most of the time and about many things – things that others would not see as bothersome. They expect the worst even though they have no evidence that disaster is about to strike. They may have narrowed their lives and limited their activities, believing that these strategies will keep them safe from catastrophe.

Panic disorder: Terror can suddenly strike in response to a specific experience or it can occur completely out of the blue. Accompanying physical symptoms are chest pains and a feeling of choking. People can feel that they are literally dying. If the panic attack is tied to a place or event, people start to avoid these at all costs. However, if the attacks simply occur with no discernable trigger, people begin to isolate as they never know where or when their panic attack may occur.

Social anxiety disorder: People are extremely self-conscious, fear that they will be judged negatively by others or that they might inadvertently say or do something that will make others dislike them. They stay away from social situations and become isolated and alone.

Specific phobias: People develop an unreasoned fear of objects or situations out of all proportion to the danger posed. Agoraphobia (agora is the Greek word for a public gathering place) is the fear of going out of their homes.

¹⁶ Anxiety Disorders Association of Canada. Available at: <http://www.anxietycanada.ca/english/>

Special note: While medications may be prescribed for phobias in the short term, the main intervention is desensitization therapy which includes three phases:^{17 18}

1. Learning relaxation techniques and coping strategies.
2. Identifying a fear hierarchy starting with the least threatening version of the frightening stimulus.
3. Working through the hierarchy of fear by exposing yourself (with the therapist's support) to the stimulus at each level of fear while practicing relaxation and coping strategies. The idea is that, overtime, the fear response is unlearned.

Obsessive compulsive disorder: People with OCD experience intrusive thoughts that cause them overpowering worry. Examples are; they've left the stove on, they didn't lock their front door, their hands are covered in germs and other thoughts specific to who they are as individuals. In response, they have developed ritual behaviors that, if repeated often enough, calm their fears. Untreated, OCD is debilitating and interferes with most aspects of life.¹⁹

Medication

Refer to Chapter 2 for a full listing of choices.

Psychotherapy

Refer to Chapter 3 for a discussion of the types of psychotherapy

It will get better. You can find peace.



¹⁷ Simply Psychology. Available at: <https://simplypsychology.org/Systematic-Desensitisation.html>

¹⁸ Anxiety Disorders Association of Canada <http://www.anxietycanada.ca/english/>

¹⁹ Anxiety and Depression Association of America.

Available at: <https://www.adaa.org/about-adaa/press-room/facts-statistics>



Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

Chapter 5 – Bipolar Disorder



Bipolar disorder is a life-long disorder characterized by periods of elevated emotions (highs) interspersed with depression (lows). Typically, a high builds over time, starting with increased energy, and a “life of the party” personality. For those who are unaware that the person has bipolar disorder, they are entertained by this expansiveness. For those who know, family and friends, there is a sense of “Oh no. Here we go again.”

Not everyone in the beginning high phase is funny and charming. Some are irritable and hard to get along with (which becomes more pronounced as the high evolves) – damaging relationships overtime.

The expression of mania can vary among people. The description below is what is generally understood as the mania associated with Bipolar I (see a description of the various types on bipolar disorder below).

When a beginning high evolves into a full blown manic episode it is characterized by:

- Almost superhuman energy and a tendency to engage in risky behaviours
- Talking excessively and flitting from subject to subject and activity to activity
- Very little or no sleep – without experiencing fatigue
- Elevated sense of self-esteem. They many declare themselves to be famous, rich or invincible.
- Poor decisions with no regard for the consequences. Examples are spending money they don't have, gambling to the point of debt or unwise and dangerous sexual activity.
- Excessive happiness unwarranted by the situation or extremely bad tempered interactions.

²⁰ Mood Disorders Society of Canada. What is Bipolar Disorder. Available at: www.mdsc.ca

Highs may include psychosis where people have delusions and hallucinations.

When people come down from a high, they may have to confront the wreckage of their lives; damaged work and family relationships, possible sexually transmitted disease, and, very likely, debt. Some have come into contact with the law due to their behaviours and now have the legal system to navigate.²⁰ Highs are followed by the lows of depression.

As with depression, suicide is a concern for people with bipolar disorder and their family and friends.

Different forms of Bipolar Disorder

- **Bipolar I** is the disorder described above; highs followed by lows.
- **Bipolar II** (Cyclothymic disorder) involves milder highs which may not even be recognized as such. The person is just sociable and full of energy. But this period is followed by depression – and that is recognized by all.
- **Rapid cycling** is where people have multiple episodes of highs and lows per year.
- **Mixed state** People have periods of highs and lows in the same day.²¹

Medications

Lithium has been prescribed for bipolar disorder since the mid-1950s. It remains the medication of choice today. When first prescribed, your psychiatrist will warn you that lithium can take several weeks to show benefits, but once therapeutic levels are reached, people experience a marked reduction in symptoms. Therapeutic levels need to be kept constant for lithium to continue to work.

Anti-depressants: ***It is not recommended that anti-depressants be used alone in bipolar disorder.***

See Chapter 2 for other medication choices.

Psychotherapy

Refer to Chapter 3 for a discussion of the types of psychotherapy

You can live a full and happy life.



Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

Chapter 6 – Post-Traumatic Stress Disorder (PTSD)

Studies show that approximately 50 percent of the general population will experience at least one traumatic event during their lifetime. However, only 7 to 8 percent will develop PTSD.^{22 23}

PTSD is talked about in the media most often in relation to military service but there are many other areas of human experience that can expose people to the risk of developing PTSD. Childhood physical or sexual abuse can lead to PTSD. Police, fire-fighters, emergency measures services (EMS) personnel and rescue workers are also at risk. Other experiences such as domestic or physical assault, rape, accidents, robberies and natural disasters can also be precipitating factors.

It does not matter if these experiences actually result in physical injury (although many do). It is the sure and certain belief that injury or death is imminent that is one of the criteria for PTSD. People who witness (but don't experience the trauma themselves) are also at risk.²⁴

There are commonalities among people who develop PTSD; the severity of the traumatic event, having poor or no social support after the trauma, a history of childhood abuse, mental illness or a family history of mental illness, living or having lived in poverty, and ongoing life stresses. Just being female is, in fact, a risk factor.²⁵

Factors that protect against developing PTSD are having a secure support system, having access to an understanding forum to talk about what has happened and learning or already knowing about ways of coping with adverse life events.

²² National Institute of Mental Health diagnostic criteria for PTSD.

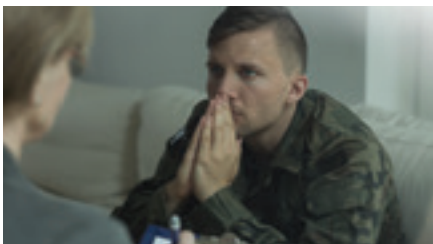
Available at: <https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>
Note this is a US figure. The PTSD Association for Canada uses this figure.

²³ National Institute of Mental Health diagnostic criteria for PTSD.

Available at: <https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>
Note this is a US figure. The PTSD Association for Canada uses this figure.

²⁴ Viewing these events online or on television is not a risk factor for PTSD.

²⁵ Brewin, C. Andrews, B. & Valentine, J. (2000). Meta-analysis of risk factors for post-traumatic stress disorder in trauma-exposed adults. Available at: https://www.researchgate.net/publication/12258580_Meta-Analysis_of_Risk_Factors_for_Posttraumatic_Stress_Disorder_in_Trauma-Exposed_Adults



Symptoms

There are four areas of symptoms that make up a diagnosis of PTSD.^{26 27}

1. **Intrusion:** Examples are: Unwanted and unbidden memories of the traumatic event, nightmares and flashbacks. Flashbacks are a sudden state of altered consciousness where people re-experience aspects of the traumatic event, as if it were happening in the present. Flashbacks can involve one or more senses, such as seeing, hearing and smelling.
2. **Avoidance:** Certain places, sounds, smells, sights or even words summon feelings of the fear that people experienced during the trauma so they develop strategies to avoid these “triggers.” But this limits more and more aspects of everyday life, to the point of isolation. Adding to the burden, the number of triggers can actually increase overtime.
3. **Negative alterations in thinking and emotions:** The world has become dangerous and they worry that more traumatic events are around every corner. Recall of the original event may be affected. People feel that no one understands what they’ve been through. They may feel extremely angry that no one warned them and now, it appears, no one will help them (even if people are trying). Self-blame is common. They feel guilty for surviving when others didn’t or they feel ashamed because, if they’d just said something or fought back, they could have saved themselves or others. They may become emotionally numb, lose interest in their usual activities, and lack a sense of future.
4. **Alterations in emotional arousal and in reactions:** Irritability and sudden angry outbursts are common symptoms of PTSD. People may blow up with little provocation. They startle easily. They are wary and tend to look over their shoulders a lot of the time, which is called hypervigilance. With their brain occupied in this manner, they have difficulty thinking, remembering and concentrating.

Current research is examining the structural and chemical changes in the brains of people with PTSD.²⁸ One finding is that there is excessive activation of the fear circuitry, as well as changes in neurotransmitter and hormone regulation. It is estimated that 50% of people with PTSD also experience major depressive disorder.²⁹

²⁶ *ibid*

²⁷ Note: PTSD is listed diagnostically as a trauma and Stress Related Disorder.

²⁸ PTSD: National Center for PTSD: Clinician’s Guide to medications for PTSD. Available at: <https://www.ptsd.va.gov/professional/treatment/overview/clinicians-guide-to-medications-for-ptsd.asp#summary>

²⁹ *ibid*

Substance abuse

Depression, anxiety and bipolar disorder have all been found to have a reasonably high chance of being accompanied by substance abuse.

Depression and anxiety – estimated at 20%³⁰

Bipolar disorder – 7 times the rate of substance abuse as the general population³¹

Post-traumatic stress disorder, however, has by far the highest rate; at 65%.³² Research on veterans show rates as high as 74%.³³

Some people report that they began to abuse drugs or alcohol as a form of self-medication – hoping to relieve themselves of the troubling symptoms of their mental illness. Others have had substance abuse problems of long standing and when they finally receive effective treatment, they discover that their substance abuse was masking a mental illness.

What the medical community agrees upon is:

- 1) substance abuse is common enough that a question about your usage will likely have been integrated into your initial psychiatric assessment
- 2) substance abuse makes mental illness worse, and,
- 3) mental illness and substance abuse problems should be treated together

There are difficulties on this last point. Despite a fairly wide understanding that both problems should be treated together, programs that specialize in concurrent disorders (as this is called)³⁴ have been slow to develop.

Knowing that your mental illness and your substance abuse problems should be treated together, ask your psychiatric and addiction teams to coordinate their treatment plans for you. Close communication among these helpers is critical to your recovery.

³⁰ Anxiety and Depression Association of America.

Available at: <https://www.adaa.org/understanding-anxiety/related-illnesses/substance-abuse>

³¹ Bouchez, C. Mental illness and substance abuse. WebMD. Available at:

<http://www.webmd.com/bipolar-disorder/features/bipolar-disorder-and-substance-abuse#2>

³² DrugRehab.com. PTSD and substance use disorders.

Available at: <https://www.drugrehab.com/co-occurring-disorder/ptsd/>

³³ National Center for PTSD. Available at:

https://www.ptsd.va.gov/professional/co-occurring/ptsd_sud_veterans.asp

³⁴ In the US, a combination of substance abuse and mental illness is called a dual diagnosis.



Medication

Special notes:

Anti-depressants: Selective serotonin reuptake inhibitors (SSRIs)³⁵ are particularly recommended for PTSD.³⁶

Anti-convulsants (mood stabilizers): Research has shown that anti-convulsants used for people with PTSD show very few positive results, with one exception; Topamax. However, evaluative research is in early stages and no strong clinical recommendation has emerged.^{37 38}

| Brand name | Chemical name |
|------------|---------------|
|------------|---------------|

| | |
|---------|------------|
| Topamax | topiramate |
|---------|------------|

Atypical anti-psychotics (as discussed in Chapter 2) are not recommended as a sole medication for PTSD but may be prescribed in conjunction with an anti-depressant.³⁹

Otherwise, refer to Chapter 2.

³⁵ This designation refers to the area of the brain the anti-depressant is aimed at.

³⁶ PTSD: National Center for PTSD: Clinician's Guide to medications for PTSD. Available at: <https://www.ptsd.va.gov/professional/treatment/overview/clinicians-guide-to-medications-for-ptsd.asp#summary>

³⁷ PTSD: National Center for PTSD: Clinician's Guide to medications for PTSD. Available at: <https://www.ptsd.va.gov/professional/treatment/overview/clinicians-guide-to-medications-for-ptsd.asp#summary>

³⁸ Berlant, J. (2006). Topiramate as a therapy for chronic post-traumatic stress disorder. Psychiatry, Vol 3 (3). Abstract available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2990556/>

³⁹ ibid

Marijuana for medical purposes

Marijuana (cannabis) is medically authorized most commonly for chronic pain but it is also available for a number of other illnesses including anxiety and PTSD. Health Canada has information for health care providers⁴⁰ and for patients.⁴¹

While the people who use marijuana feel it helps, medical opinion is mixed on its effectiveness with some experts pointing to research findings that show that it only worsens the symptoms of mental illness.⁴²

Marijuana remains a controversial subject so inform yourself and consult with your health team before proceeding.

Psychotherapy particularly for PTSD

As with depression, anxiety and bipolar disorder, the best results for PTSD occur when medication is paired with therapy. In addition to those therapies discussed in Chapter 3, there are other forms especially for PTSD.

The three-phase model (which all therapies adhere to)

The 3-phase model of PTSD treatment informs the therapies as described below. Each has its own approach to treatment but all will address, in some way, the following phases:

Phase 1 Safety and stabilization: This involves developing skills to self-soothe and improve self-care. The skills provide a platform of emotional and physical safety from which to proceed through other aspects of the chosen therapy.

Phase 2 Trauma memory processing: People will begin to talk through their experience of trauma in a safe a secure way, pacing themselves as slowly as they wish. In so far as possible, people begin to makes sense of the traumatic events that have shaped their lives. This is not a linear process. People can go back and forward in time as it suits them.

Phase 3 Recognition: People's experiences of trauma no longer drive their thinking and actions. They are now in charge of their own lives and decisions.⁴³

⁴⁰ Information for healthcare practitioners on the medical use of cannabis. Available at: https://www.canada.ca/en/health-canada/topics/accessing-cannabis-for-medical-purposes.html?_ga=2.130897545.767762009.1497540778-1964565611.1497540778

⁴¹ Accessing cannabis for medical purposes (several guides for patients). Available at: https://www.canada.ca/en/health-canada/topics/accessing-cannabis-for-medical-purposes.html?_ga=2.130897545.767762009.1497540778-1964565611.1497540778

⁴² Government of Canada. Health risks of marijuana. Available at: <https://www.canada.ca/en/health-canada/services/substance-abuse/controlled-illegal-drugs/health-risks-of-marijuana-use.html>

⁴³ Traumaline1: What is tri-phasic trauma therapy. Available at: <http://traumaline1.com/node/108>

Prolonged exposure therapy: Similar to desensitization therapy for phobias (as discussed in Chapter 4), this therapy's goal is to help people control their fears by describing their trauma in measured increments and in conjunction with relaxation techniques and coping strategies. It begins with the absolutely least threatening version of the traumatic event – identified and agreed to by the person experiencing PTSD. Over time, there is a very gradual increase in the details along with a precise description of accompanying emotions and bodily sensations. This cannot be rushed. It goes exactly at the pace the person with PTSD can tolerate.⁴⁴

Cognitive restructuring: This form of therapy helps people “restructure” their thoughts and memories in a realistic way. Examples can be: It was not my fault, there is no need to feel shame or guilt. There was nothing I could have done.

The overall goal of both these therapies is to allow people to integrate their traumatic memories into their life story. Doing so takes away the power of their memories to run their lives in distressing and negative ways. In short, to make the memories just part of who they are.

Anger management: Many people have anger management problems but PTSD places people at a much higher risk of outbursts and assaults. Anger management is a process of learning to monitor the early signs of your anger and learning skills to deal with it effectively. People learn how to express anger effectively – before they reach the blow-up stage.⁴⁵

Eye movement desensitization and reprocessing therapy (EMDR): This remains a controversial therapy but many people value it. People follow a stimulus back and forth with their eyes (a light or the therapist's finger) while they recall their traumatic memories. The theory is that the rhythmic eye movements assist them to integrate their memories into a more whole sense of self, while at the same time, diminishing their intrusive power.⁴⁶

Peer support for PTSD

It is hopeful and uplifting to be with people who have survived trauma and even thrived. Peer support is especially useful for those who are members of particular professional cultures; military, police, EMS, firefighters, or rescue workers. In fact, they may be comfortable only when they are among members of their own profession who “get it.”

You will not be defeated. You will win.

⁴⁴ PTSD: National Center for PTSD: Clinician's Guide to medications for PTSD. Available at: <https://www.ptsd.va.gov/professional/treatment/overview/clinicians-guide-to-medications-for-ptsd.asp#summary>

⁴⁵ Mayo Clinic. Anger management. Available at: <http://www.mayoclinic.org/tests-procedures/anger-management/home/ovc-20325680>

⁴⁶ VA/DOD Clinical practice guidelines for the management of post-traumatic stress disorders and acute stress disorder. Department of Veteran Affairs. Department of Defense (US).



Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

Chapter 7 – Ongoing support strategies

While medication is an important feature of your treatment plan – and therapy only improves your chances of recovery, there are lots of things you can do to support your own wellness.

Developing an array of “do-it-yourself” strategies is empowering. Illness of all kinds, but particularly mental illness, leaves you feeling a loss of control over your life. While your physician or psychiatrist, and your other medical supports offer important help, they are only a small part of your day-to-day reality. There are many things you can do for yourself.⁴⁷

Some places to start

Let friends, family, co-workers and others help: You cannot do this alone. It may seem that there is no one who cares, but they are there. It is true that some may ignore you or turn their backs. The stigma of mental illness is lessening but it still exists. But even just a few close supports can make all the difference in your recovery. Nonetheless, it is wise to choose carefully. People who drag you down only add to your burden. Perhaps now is the time to take an inventory of your relationships and distance yourself from those who diminish, rather than enhance your health.

Community: Do you have a place where you belong? To some, this means a religious affiliation. To others, it's the town where you live, the profession you've chosen, your fellow sports fans or your “girlfriend” network. Also, cultural identity and belonging go hand in hand. People draw strength from community – it holds them up during the tough times and it welcomes their contributions when it's their turn to give back.



⁴⁷ Mood Disorders Society of Canada (2012). What better feels like: Wellness guide.
Available at: <https://mdsc.ca/what-better-feels-like/>

Strategies for handling stigma: It's there and it can hurt. Know that you don't have to tell anyone that you have a mental illness. Develop ways to assess places and people for whether or not they are safe. The Mood Disorders Society of Canada has developed one such safety strategy. It's the Elephant in the Room anti-stigma campaign. Thousands of people have ordered the symbolic little blue elephant. They place it on their desks, in the class room or just keep it with them. It has a visual message: "Here you are safe. You can talk about your mental illness if you want to." See: The Elephant in the Room: <https://mdsc.ca/stigma/elephant-in-the-room-campaign/>

Taking care of your physical health: Yes, we all know we should exercise, eat right, get a good night's sleep, stop smoking and go easy on the alcohol. But knowing and doing are two different things. Now is the time to get serious about your whole body health – if you haven't before. Commit to yourself. After all, you deserve it!

Peer support: There is no substitute for being among people who've "been there." This may involve a formal peer support group or connecting with individuals who will meet you for coffee. You will learn from these people and they will learn from you. What peers offer is the knowledge of their experience - practical, every day and common sense. Online peer-to-peer support is also valuable.

Peer support can also help your family or friends who are going through their own struggles. Coping with a mental illness has likely been all-consuming for you but it is also no walk in the park for your support system. They can use a place of their own to turn to so they know that they, too, are not alone.

Inform yourself: Research the internet, ask questions, track down information, learn about and bookmark trusted sources. A knowledgeable patient is the medical profession's best friend. Your questions for them will be more targeted and you will provide them with information that will help them better manage your care.

Alternative and traditional therapies:⁴⁸ Usually, the medical profession takes the view that, if alternative therapies work for you and create no harm, then go ahead. Some people stand by meditation and it has shown itself to enhance calmness, reduce stress and sharpen concentration. Taking dietary supplements is also a choice even though scientific research on their effectiveness is not strong. The exception to these negative results is St. John's Wort which has shown itself to be effective for mild depression. Exercise helps lift mild depression, sometimes just as well as anti-depressants. Light therapy for seasonal affective disorder is endorsed by the medical community and widely used. Yoga is helpful for people with mild symptoms, although positive evaluative research results are not strong. Indigenous healing practices, traditional Chinese medicine or Ayurvedic medicine have much longer histories than Western practices. They focus on a balance between the mind, body and spirit. They also have the advantage of connecting people to their culture.

⁴⁸ Kennedy, S. et al (2016). Canadian Network for Mood and Anxiety Treatments (CANMAT). Clinical guidelines for the management of major depressive disorders in adults. Section 3 Pharmacological treatments. Canadian Journal of Psychiatry, Vol 61 (9). Available through subscription to the Journal.



Having fun: Mental illness steals the enjoyment out of life. Having fun may seem only a memory and it just doesn't seem right that you have to work at something that used to be so spontaneous. Knowing that fun is not a luxury but an essential part of your health may help you get out and get going.

Giving back: As you progress in your wellness, you may want to help others, noting that you must have a firm grip on your own health before offering support. Become a peer supporter or join a speakers' bureau and tell your story to others. Participate in the Defeat Depression walk <http://www.defeatdepression.ca/>. If you are feeling really feisty, become an advocate. You can work through known advocacy groups, start a blog or a chat room, or participate in an educational video. There are lots of ways to give back if you want to – choose one that suits you.

**You may bend but, with support,
you will not break.**



Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

Chapter 8 – Recovery and relapse prevention



Recovery

Recovery is a term to describe living well despite having a mental illness or an addiction. Recovery focuses on strengths and talents. It preserves your hope and optimism. It is a concept that urges you to live a full life every day. Using the term signals that you have integrated the experience of your mental illness into your sense of self and into your life. You are not your illness. It is only one aspect of your identity.⁴⁹

⁴⁹ Mood Disorders Society of Canada (2012). What better feels like: Wellness Guide.
Available at: <https://mdsc.ca/what-better-feels-like/>

Relapse prevention

You've worked so hard to deal effectively with your mental illness – and you have achieved wellness that once upon a time, you felt was impossible. You can relax now. No, you can't. Although it doesn't seem fair, you have to actively maintain your wellness or it is in danger of slipping away. In other words, you need to guard against a relapse. Relapse cannot always be prevented, but you are in a much stronger position to avert it if you know that it is possible and if you have strategies to prevent it (or make it as short as possible). It means keeping a close eye on things.⁵⁰

- Know the language of response and remission and how these terms relate to your situation.

Response: You may respond to your medications, meaning things are much better, but you're still not back to normal. There is more that can be done and you need to work with your doctor to find options. Don't wait.

Remission: You feel back to normal. Remission, however, implies that there could be a relapse.

- Just knowing that relapse can occur puts you ahead of the game. If it does happen, it can be disheartening but you will be well again. No, it's not easy to hang onto hope but you've gotten better before and you will again.
- Identify the early warning signs of not doing well. Don't wait. Take action. Hope is generally a good thing but when you use hope as a form of denial – to delay facing facts, it stops being helpful and starts being dangerous.
- Enlist trusted friends and family in your relapse prevention plan – you may not be your own best observer but family and friends have seen you when you are well, when you start to slide and at your worst. They know what to look for and can tell you when you are starting to slip.
- Keep working on your support strategies. After all, they are just plain good for you.
- Maintain contact with your physician and psychiatrist, for regular wellness checks.
- If you have included peer support in your personal wellness strategy, maintain engagement with your group or other peers.
- One of the pitfalls of the joy of achieving wellness is feeling like you don't need medication anymore. Never discontinue medication suddenly, even when you get the go-ahead from your medical supports. Your body has become accustomed to it and will react in what is called a rebound effect. Taper off slowly as rebound is serious and can tip you right back into having symptoms.

Recovery is living well

⁵⁰ ibid



A selection of online resources

Advanced research

| | |
|--|--|
| WebMD | webMD.com |
| Mayo Clinic Patient care and health information | mayoclinic.org |
| National Library of Medicine MedlinePlus | medlineplus.gov |
| MedicineNet | medicineNet.com |
| National Institute of Mental Illness | nimh.nih.gov/health |

Associations

| | |
|-------------------------------------|--|
| Mood Disorders Society of Canada | mdsc.ca |
| Canadian Mental Health Association | cmha.ca |
| PTSD Association of Canada | ptsdassociation.com |
| Anxiety Association of Canada | anxietycanada.ca |
| National Alliance on Mental Illness | nami.org |

Advocacy

| | |
|--|--|
| Canadian Alliance on Mental Illness and Mental Health | camimh.ca |
|--|--|

© 2018 by Mood Disorders Society of Canada. All rights reserved. No part of this document may be reproduced or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission of Mood Disorders Society of Canada



Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada