

Obsessive-Compulsive Disorder

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*Dr Peter Adams
Dr Nick Argyle
Jo Beck
Lorraine Burns
Joanne Chiplin
Dr Hugh Clarkson
David Codyre
Kate Cosgriff
Assoc. Prof. John Coverdale
Dell Coyte
Dr Sue Crengle
Annie Cripps
Diane Davidson
Rodney Davis
Sandra Duncan
Fuimaono Karl Pulotu Endemann
Mali Erick
Katherine Findlay
Jade Furness
Ani Goslyn
Chris Harris
Health & Disability Commissioner
Carmen Hodgson
Marie Hull-Brown
Beryl Jane
Virginia Lau
Shelley Mack
Dr Hylton Greig McCormack*

*Ian MacEwan
Dr Peter McGeorge
Dr Jan McKenzie
Dr Pam Melding
Jennie Michel
Sharon Milgrew
Dr Brandon Nementzik
James Nichol
Assoc. Prof Mark Oakley-Browne
Mary O'Hagan
Maureen O'Hara
Dr Tina Paige
Steven G Patterson
Janet Peters
Dr Chris Perkins
Julie Purdy
Sue Robertson
Schizophrenia Fellowship
Dr Rob Shieff
Dr Sandy Simpson
Kenneth Smedley
Suzy Stevens
Lorene Stewart
Alison Taylor
Cindi Wallace
Prof. John Werry
Rick Williment
Monique Wilson*

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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.

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 research@mentalhealth.org.nz
Web www.mentalhealth.org.nz

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Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is a condition where a person has obsessional, uncontrollable thoughts and performs compulsive and repetitive actions. It is sometimes called a disorder of checking or doubting as these things are both common in OCD.

To have a few obsessional thoughts or minor compulsions is extremely common. The thoughts and actions of OCD disrupt people's lives in a most distressing way.

Obsessions are repetitive and unwanted thoughts, images or impulses which cause anxiety and are hard to stop. In fact, trying to stop them causes more distress. If you have OCD you know that these things come from your own mind, just like other thoughts, images and impulses, but you find them much harder to control. They are very different from the kinds of usual worries which might stay in your mind when you are focussed on a particular problem.

Compulsions are repeated actions or behaviour which a person feels driven to do, even though they know they are unnecessary or don't make sense. The compulsions are usually linked to the obsessional thoughts, that is, performing the compulsion temporarily relieves the anxiety and distress caused by the thoughts. For example, obsessional thoughts about your hands being dirty lead you to feel anxious about catching a disease. This leads to repeatedly and excessively washing your hands.

Some compulsions seem bizarre or silly, like touching things, counting things or putting them in exact order or symmetry. A person with OCD might hang washing out in an exact order and feel compelled to take it all down and put it up again if they think they have got the order slightly wrong.

Some actions become rigid or like rituals. The person may touch things, wash their hands in an exact sequence or a particular number of times. Compulsions can also be unseen. They may include counting or praying silently, feeling compelled to think particular thoughts, or to produce particular mental images.

When people perform the compulsive action they do feel a little better initially. But then the anxiety returns and, as time passes, doing the compulsion has less effect on it. This can lead to more and more compulsive behaviour in an attempt to control the rising level of anxiety.

It is important not to mistake OCD for a personality problem. Some people have what might be called obsessional personalities. They are very careful and check things more thoroughly than most of us. They may be perfectionists and have very high standards in some areas. In fact it is necessary to be a bit obsessional in many jobs. We all hope that doctors or air traffic controllers will be very careful and check their work thoroughly. Some people have particular obsessions like never throwing anything away. Usually these tendencies do not cause great problems unless they are very noticeable, in which case they may impact on relationships with other people.

Surprisingly, most people who develop OCD do not seem to have had obsessional personalities beforehand. Some people with obsessional personalities enjoy their high standards and super-clean houses. No one enjoys having OCD.

Symptoms of obsessive-compulsive disorder

The main symptoms of OCD are the obsessions and compulsions. The content of these varies from person to person, but common themes are:

- dirt and contamination which leads to excessive washing and avoiding possible dirt
- doubt leading to checking that things have been done properly - like locks being locked and stoves turned off
- unusual or repulsive images. These may be about religion, sex, violence or suicide and may raise unrealistic fears about the safety of the person or their family or whanau.

Obsessions and compulsions are:

- more than just excessive worries about real-life problems
- severe enough to be time-consuming - that is, they take more than one hour a day, and cause significant distress
- significant enough to interfere with normal daily activities and relationships.

An adult with OCD is usually aware that the obsessional thoughts or impulses are unreasonable and are a product their own mind (as opposed to feeling that someone or something else has put them there). They usually try to ignore or suppress these thoughts, impulses or images with some other thought or action.

People who get obsessive-compulsive disorder

About two percent of people will have significant OCD. About one third of people with OCD will have symptoms starting in childhood, adolescence or early adult life. OCD is equally common in males and females although it usually starts later for females.

Typically OCD starts gradually and can be a minor irritation for years, eventually getting to the point where it can no longer be denied.

A person may, for example, deal with the obsessional thought of being dirty by washing a bit more and keeping things cleaner. Taking a shower two or three times a day might not affect anyone much. If this increases so that the person spends an hour in the bathroom each morning, it becomes quite inconvenient for the household. If it increases so that they spend three hours in the bathroom each day, their life has really been changed.

Five to ten percent of people with OCD have periods of the disorder but feel quite well in between. Another five to ten percent have a more severe illness which just gets worse. Treatment can greatly improve OCD but, because this is a long-term illness, treatment is often long-term too. There is a risk that people with OCD do not know that they are ill and that they can be helped. Many people with OCD do not seek help until they have had the disorder for five to ten years.

The outlook without any treatment is not very good. OCD usually lasts a long time, getting worse at times when the person is stressed.

It is most important to seek help. Start by going to see your general practitioner. OCD often needs the help of a psychologist, or in more severe cases, a psychiatrist. Do not

wait till OCD has ruined your life before getting help because treatment is very effective for almost everyone.

Related conditions

OCD is driven by the anxiety that comes with obsessions and compulsions. This anxiety can become extremely severe. Sleep is often disturbed. Depression is also very common. It may be there from the start or it may develop as the person gets worn out by the OCD. Some people become suicidal when their OCD is severe and lasts for a long time.

Anxiety and panic attacks can also occur. Addiction may become a problem if you try to reduce your OCD symptoms with alcohol or illegal drugs.

Five to ten percent of people with OCD have sudden and involuntary movements called tics, often about the head or face. They may make sudden sounds or say or shout obscene words. Their problem may be part of another disorder called Tourette disorder.

The main myth about OCD

NOT TRUE *OCD is just being careful or fussy.*

OCD feels unpleasant and unhelpful to people who have it. They get no pleasure from their repeated actions and rituals.

Causes of obsessive-compulsive disorder

Biomedical theory of OCD

The exact cause of OCD is unknown but there is strong evidence that OCD has a physical cause in the brain.

In the centre of the brain there is an area of nerve cells called the basal ganglia. This area is thought to be responsible for starting and stopping thoughts and actions and responding to new information. If this area is not working correctly it may mean, for example, that when you look to see if the door is locked this information does not register properly and you therefore do not stop the action of checking the locks. The chemicals active in this part of the brain are serotonin and dopamine. Serotonin is affected by most medications that have been found to be useful in treating OCD as they increase its activity in the brain.

There is a clear genetic (inherited) factor in OCD. If you have OCD, your children have more risk than most people of getting OCD, although it is still more likely that they will not develop the condition.

Cognitive-behavioural theory of OCD

Cognitive and behavioural psychology examine how we think and act. The cognitive-behavioural explanation of OCD proposes that obsessional thoughts continue because the person cannot stop or ignore them easily. This is often because they have depression which weakens their ability to distract themselves from intrusive thoughts. Compulsions are the way a person tries to relieve the anxiety produced by obsessive thoughts but compulsive rituals such as hand washing after obsessive fear of contamination produce only temporary relief. Then anxiety builds up again. Every time the compulsion is

repeated it gets harder to resist. Because people learn to seek relief in this way they do not ever get the chance to learn that in routine living, their chance of developing an infection is very small indeed. In this way, OCD is rather like an addiction. The more you do it, the more you have to do it again.

OCD may be triggered by stresses which increase anxiety. Fatigue may also trigger OCD or make it worse, by making people generally more vulnerable and less able to cope.

People with OCD may believe they developed it because of stress or things have gone wrong in their lives. Other people with OCD cannot so easily find things that have gone wrong in their lives. They may agree with the view that their mental illness is genetic or biological in origin. A lot of people with mental illness believe it is a combination of these things. Sometimes people think their illness is a punishment for their moral or spiritual failure. It's important to remember that it is not your fault you have a mental illness.

Families and whanau, especially parents, can worry that they caused their relative to develop OCD. 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 Obsessive Compulsive Disorder

OCD is an unusual and sometimes frightening condition. Many people with OCD are afraid that they are going mad and will completely lose control of themselves. This does not happen. OCD does not lead to other severe illnesses like schizophrenia, but for some people it can be just as disabling.

OCD wastes time and robs people of parts of their everyday life. Obsessional thoughts can interrupt concentration making study or work difficult. If OCD is present in teenage years and early adult life it can interfere with relationships and people with the disorder may feel quite isolated. Without help or understanding you may lose close friends because you have no time for them, or because they cannot put up with your 'odd' behaviour.

Initially a person with OCD may hide their problems through fear or embarrassment. Or they may start making demands of others. For example, they may try and prevent their family or whanau from bringing anything that might be dirty into the house, or demand that they wash their hands more than is necessary. When OCD is severe the rest of the household is likely to be experiencing its effects.

If you live with someone who has severe OCD this will have a big impact on your life. You will want to encourage them to have therapy and stick with it, partly for your own sake. If the situation at home becomes very tense you will need some time to yourself so you remain healthy. If the going gets really hard for you, it might be important to seek out a friend, or a professional, in order to talk through your problems and get advice. It is important to remember that helping loved ones with OCD is hard work.

Consumer views¹

Living through OCD can be one of the most overwhelming, frightening, isolating and debilitating experiences a person can have. People may feel their world has fallen apart, that everything is black or that nothing makes sense. Worse still, people experiencing OCD often lose hope or the belief that they can recover and lead a worthwhile life. But those of us who have come through episodes of mental illness are able to look back and see how temporary 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 their OCD and often try to hide it as they can sense other people's fear and prejudice. Media coverage can give the wrong impression that people with mental illness are likely to be violent. 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 or controlling about lives of people with OCD. None of this helps. Sometimes the discrimination feels worse than the illness itself.

Support and information

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

Using services

Many people with OCD, 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 with OCD to seek help because they feel ashamed and want to hide their distress. Acknowledging they have a mental health problem and need help can be very scary. People with mental illness 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

Many people with OCD make a good recovery. But even if you continue to experience it you can still 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

- Learn about obsessive-compulsive disorder and the treatment options. Health professionals and others involved in helping you should provide information in a way and at a pace that is comfortable for you, and, if applicable, your family or whanau.
- Take an active part, as far as possible, in decisions about treatment. Being involved in decisions is the best way to ensure you can make informed choices about what is best for you.
- Have the continuing support of family or whanau and friends who know about the condition and understand what they can do to support you. Get treatment and support from people you trust, who expect the best for you and are able to accept how you are at any time. Involve family or whanau, friends or other important people in your treatment programme if you wish.
- Find the ways of coping that work best for you. These are different for each person, but are a critical step towards helping overcome OCD.
- Have the opportunity to get support from culturally appropriate self-help groups that can give you information and support. Learning that others have this problem can be a great relief if you have been keeping it all to yourself.
- Try not to give in to your OCD. This is because the more you repeat your compulsions and rituals the more they grow.
- Do not take alcohol or illegal drugs to reduce your anxiety. These will not cure your OCD and you may become addicted to alcohol or develop other alcohol or drug-related problems.
- Talk to your health professional if you are considering stopping treatment and work together with them to find some compromise that will ensure continuing wellness but address any concerns you may have about the treatment.

Family or whanau views

Families and whanau often experience real grief, isolation, powerlessness and fear as they witness their loved one struggling with OCD. During a crisis they may find that they cannot understand the person's feelings or behaviour. 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 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 about their relative. 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 OCD. Their other family or whanau relationships can get neglected when the needs of the person with OCD 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 OCD 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 mental illness blames their family or whanau and does not want them to be involved in their care. If families and whanau can share information, skills and support with their relative and the professionals who look after them, the likelihood of recovery is much greater.

Important strategies to support recovery

Family, whanau and close friends of someone with OCD have found the following strategies important and useful.

- Learn what you can about the disorder, its treatment, and what you can do to assist recovery. Sometimes the person with OCD finds it difficult to explain to others how hard it is for them, or they have trouble understanding what is happening to them and their behaviour. If you can learn about OCD then you can understand the pain your family or whanau member or friend feels and how difficult it is for them to do things that seem simple to the rest of us.
- Do not blame the individual for having OCD. You are most helpful if you can be sympathetic without going along with any unrealistic demands.
- Understand the symptoms for what they are, not take them personally or see the person as being difficult or fussy.
- Be encouraging and but also accept that change will probably be slow. Praise any progress and accept there will be some bad days when the person needs more support.
- Find ways of getting time out for yourself and feeling okay about this. It is critical to do what is needed to maintain your own wellbeing.

Treatment of Obsessive-Compulsive Disorder

Summary of treatment options

Treatment of OCD involves two major components - psychological therapy and medication. Alone, each form of treatment is effective for 70 percent of people who have OCD. Used in combination, they will help 80-90 percent of people with OCD. Behavioural therapy is somewhat better for compulsions and medication for obsessions, but either can be useful.

Psychosocial treatments

Psychological therapy is the main component of this group of therapies for OCD. Behavioural therapy is the form of psychological therapy which has been found helpful in the treatment of OCD. Any therapy should be provided to people and their families and whanau in a manner which is respectful of them and with which they feel comfortable and free to ask questions. It should be consistent with and incorporate their cultural beliefs and practices.

Medication

The most important medications for OCD are some of the antidepressant group. Those that increase the activity of the brain chemical messenger serotonin are most effective. Even if the person is not depressed these are useful in OCD. Tranquillisers may be used briefly to reduce high anxiety early in the course of treatment. They are rarely used for any length of time because they have no long- term effect on the symptoms of OCD and because they often cause addiction problems.

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.

Complementary therapies

Complementary therapies which enhance people's lives may be used in addition to therapy and prescription medicines.

Psychosocial treatments

Behavioural therapy

OCD is a terrible trap. Although people with the disorder realise the senselessness of their repetitive compulsive behaviours, they are powerless to resist performing them as this is their only relief from the anxiety caused by their recurring obsessions. People with OCD come to believe that they, and other people, are kept safe because of the repetition of these behaviours. This belief keeps OCD going.

Behavioural therapy works by encouraging the person with OCD to challenge this belief. If you can allow yourself to repeatedly experience your obsessions without following them by compulsive behaviours, you soon come to learn that the disaster you fear so much is most unlikely to occur. As a result, the protective power of the compulsions dwindles, and they occur less often. Obsessions become less frequent and the anxiety they cause starts to fade.

The behavioural therapeutic technique used to help people with OCD is called exposure and response prevention. Because the idea of stopping the compulsions is alarming and distressing to people with OCD, the technique is carried out in a slow, systematic, step-by-step way. Therapists, family or whanau members and friends often work together to give the person with OCD all the support and encouragement they need in order to start saying 'no' to their compulsions.

Over some weeks, with hard work and frequent repetitions of the therapy tasks, significant progress is often seen.

Behaviour therapy is very effective for around 70 to 80 percent of people with OCD. They will have very good results which may last for some years. Unfortunately, most general practitioners do not have the time or training to do behavioural therapy. This is most often done on a one-to-one basis with the help of a psychologist or other trained health professional. Most specialist community mental health services attached to hospitals deal only with the most severe cases. Those who meet their criteria for acceptance will receive treatment free of charge. At a number of community service agencies charges are based on your ability to pay. Private therapists' fees may range from around \$60 to \$200 per session but many also have a sliding scale of fees.

Medication

Antidepressants

Antidepressants are also effective for treating OCD and work even if you are not depressed. As mentioned above, they are often used along with psychological therapy. They have no immediate effect and all need to be taken regularly, once or twice a day. They take up to two weeks to work and there are a number of side effects. You may need to try different medications to see which one suits you. One drug would be tried for eight to 12 weeks to see if it was helpful. For people with OCD, antidepressants are often used at a slightly higher dose than for depression. Almost all are in tablet or capsule form. They are not addictive, but there may be a small rebound effect of anxiety and insomnia if you suddenly stop taking them. The side effects (see below) vary from person to person.

Antidepressant medications do not completely cure OCD. They are likely to remove a number of symptoms, which is important as this change almost always causes a significant improvement in the quality of your life. However you may still be at some risk of OCD recurring if you stop taking them. It is hard to know exactly how long to stay on medication. They are usually given for six months or more. If you have had OCD more than once and it has been very damaging to your life, you may be advised to stay on them longer, perhaps for many years.

Antidepressants effective in OCD increase the activity of the brain chemical, serotonin. There are two groups of antidepressants used in its treatment - the older, tricyclic drugs (TCAs) and the newer Selective Serotonin Re-uptake Inhibitors (SSRIs).

Selective serotonin re-uptake inhibitors (SSRIs)

Over the past decade the Selective Serotonin Re-uptake Inhibitors (SSRI) antidepressants have become available. SSRIs have their effect specifically on serotonin. This type of antidepressant is usually first choice for treatment of OCD because they are effective and usually have fewer side effects than the tricyclics

Compared to tricyclics, SSRIs rarely cause drowsiness although nausea, headaches and sexual problems may be more common. With SSRIs there are fewer problems with other medications, alcohol, and other illnesses, except if you have severe liver or heart disease. They can affect some medicines, especially those taken for epilepsy.

The SSRIs available in New Zealand are fluoxetine (Prozac, Lovan, Plinzine & Fluox), paroxetine (Aropax) and citalopram (Cipramil).

Unfortunately it is hard to predict who will respond to which medication and who will have side-effects. For people who do not have much benefit from the antidepressants alone, other medications may be added. Combinations of medicines should usually only be prescribed by a specialist.

Tricyclic antidepressants (tricyclics/TCAs)

The only medication within the tricyclic group of antidepressants which is a specifically effective treatment for OCD is clomipramine (Anafranil, Clopress). In the early stages of treatment this may cause dry mouth, constipation, tremor, and blurred vision. These problems often go away after you have taken the medication for two to three weeks. Less common side effects are nausea, dizziness, low blood pressure, weight gain and sexual problems.

Clomipramine (Anafranil, Clopress) is often sedating which can be useful to help you sleep at night but may also cause drowsiness during the day. Alcohol should be avoided as its effects are magnified with tricyclics. While this may seem quite an alarming list of side effects, many people have only minor problems and tolerate this medication well. It is usual to start at a lower dose and build up over several weeks to see how much you need, and to check for side effects.

Tricyclics can affect the heart and an ECG (heart recording) is often done if you are over 50. Precaution is also needed if you have epilepsy, glaucoma, liver disease or problems with urination. They are very dangerous in overdose.

SSRI-like medications

The newest generations of antidepressants target serotonin and noradrenaline neurotransmitter systems. Overseas studies suggest these medications may also be effective for treating OCD however no conclusive results are yet available. There are two available - nefazodone (Serzone) and venlafaxine (Effexor). Venlafaxine is not subsidised, and depending on dose, may cost up to \$400 per month.

For more information on antidepressants refer to the medication section of the MHINZ booklet on Depression.

Benzodiazepines (tranquillisers)

The common tranquillisers are called benzodiazepines (the valium type of medications). They are used to treat anxiety symptoms. They have no effect on the presence of obsessions or the performance of compulsions. 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.

There are two ways of taking benzodiazepines. One is for very short periods to relieve great distress or allow you to cope with some important event you cannot avoid. The other, less common way, is to take them regularly for weeks or months to reduce anxiety. Because they are known to be addictive they are usually only prescribed for short periods (up to 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. If you have trouble with addictions they are best avoided.

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. They magnify the effects of alcohol, so this should be avoided.

Side effects of benzodiazepines

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

Medicine interactions

Most psychiatric medicines tend to react with each other when taken in combination. 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 such as St Johns Wort) you are taking, as some taken together can be dangerous. You should not mix different types of antidepressants unless instructed by your doctor, as this could be very dangerous.

Complementary Therapies

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

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

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

Islands' people involves massage, herbal remedies and spiritual healers.

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

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

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

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

Legislation

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

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

Recommended publication

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

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

Ministry of Health

133 Molesworth Street
PO Box 5013
WELLINGTON

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

Mental Health Commission

PO Box 12479
Thorndon
WELLINGTON

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

Department for Courts

PO Box 2750
WELLINGTON

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

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

The Health and Disability Commissioner Act 1994

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

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

The Act's objective is achieved through

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

Code of Health and Disability Services Consumers' Rights

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

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

The Health and Disability Commissioner

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

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

Ph 09 373 1060
Fax 09 373 1061

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

Ph 04 494 7900
Fax 04 494 7901

The Human Rights Act 1993

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

Human Rights Commissioner

Freephone 0800 496 877

TTY (teletypewriter) access number 0800 150 111

Email infoline@hrc.co.nz

Web www.hrc.co.nz

AUCKLAND

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

Ph 09 309 0874

Fax 09 377 3593

WELLINGTON

Level 8, Vogel Building
8 Aitken Street
PO Box 12411, Thorndon
Wellington

Ph 04 473 9981

Fax 04 471 0858

CHRISTCHURCH

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

Ph 03 379 2015

Fax 03 379 2019

The Privacy Act 1993

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

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

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

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

The Privacy Commissioner.

Freephone 0800 803 909

Office of the Privacy Commissioner

PO Box 466

AUCKLAND

Ph 09 302 8655

Email privacy@iprolink.co.nz (Auckland)

privacy@actrix.gen.nz (Wellington)

Web www.privacy.org.nz

Further information

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

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

The Mental Health (Compulsory Assessment and Treatment) Act 1992

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

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

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

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

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

Further information

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

The Schizophrenia Fellowship (SF)

Freephone 0800 500 363

National Office

PO Box 593

Christchurch

Ph 03 366 1909

Fax 03 379 2322

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

Groups and organisations

The Phobic Trust of NZ Inc

Freephone 0800 14 ANXIETY (0800 269 4389)
24 hour support line
Web www.phobic.org.nz

AUCKLAND
77 Morningside Drive
St. Lukes
P O Box 41 133

Ph 09 846 9776
Fax 09 849 2375
Email clinic@phobic.org.nz

WELLINGTON
19 Normanby Street
Newtown

Ph 04 389 7210
Fax 04 389 3590
Email clinic@phobic.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

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

Obsessive Compulsive Foundation (US)

www.ocfoundation.org

Expert Consensus Treatment Guidelines for Obsessive Compulsive Disorder: A Guide for Patients and Families

www.psychguides.com/oche.html

Obsessive Compulsive Disorder Websites

www.geonius.com/ocd

Books

Brain Lock: Free Yourself from Obsessive-Compulsive Behaviour by J. Schwartz. Harper Collins, 1997.

Freeing Your Child from Obsessive Compulsive Disorder: A Powerful Program for Parents of Children and Adolescents by Tamar E Chansky. Times Books, 2001.

Getting Control: Overcoming Your Obsessions and Compulsions by L. Baer. Plume, 1991.

Nine, Ten, Do It Again. A Guide to Obsessive Compulsive Disorder by K. L'Anson. Obsessive Compulsive and Anxiety Disorders Foundation of Victoria Inc., 1997.

Obsessive Compulsive Disorder: Help for Children and Adolescents by Mitzi Waltz. O'Reilly & Associates, 2000.

Stop Obsessing: How to Overcome Your Obsessions and Compulsions by E. Foa and R. Wilson. Bantam, 1991.

The Boy Who Could Not Stop Washing: The Experience and Treatment of Obsessive Compulsive Disorder by J. Rapoport. New American Library, 1997.

The Habit Change Workbook: How to Break Bad Habits and Form Good Ones by James Claiborn and Cherry Pedrick. New Harbinger, 2001.

The Imp of the Mind : Exploring the Silent Epidemic of Obsessive Bad Thoughts by Lee Baer. Plume, 2002.

The Sky is Falling: Understanding and Coping with Phobias, Panic and Obsessive-Compulsive Disorders by R. Dumont and A. T. Beck. W.W. Norton, 1997.

When Once is Not Enough: Help for Obsessive-Compulsives by G. Steketee and K. White. New Harbinger Publications, 1990.

Obsessive-compulsive Disorder: The Facts by Padmal de Silva. Oxford University Press, 1998.

Mental Health Foundation Resource & Information Centre

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

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

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

Mental Health Foundation of New Zealand

PO Box 10051
Dominion Road
Auckland

81 New North Road
Eden Terrace
Auckland

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

Titles in the MHINZ series of booklets

<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>
<i>Complementary Therapies in Mental Health</i>	<i>Separation Anxiety Disorder</i>
<i>Delusional Disorders</i>	<i>Solvent and Inhalant Problems</i>

