Clinical Corner – What is Obsessive-Compulsive Disorder (OCD)?

Obsession Compulsive Disorder (OCD) is an anxiety disorder where a person has recurrent and unwanted ideas or impulses (called *obsessions*) and an urge or *compulsion* to do something to relieve the discomfort caused by the obsession. The obsessive thoughts range from the idea of losing control, to themes surrounding religion or keeping things or parts of one's body clean all the time. Compulsions are behaviors which help reduce the anxiety surrounding the obsessions. Most people (90%) who have OCD have both obsessions and compulsions. The thoughts and behaviors a person with OCD has are senseless, repetitive, distressing, and sometimes harmful, but they are also difficult to overcome.

OCD is more common than schizophrenia, bipolar disorder, or panic disorder, according to the National Institute of Mental Health. Yet it is still commonly overlooked by both mental health professionals, mental health advocacy groups, and people who themselves have the problem.

You Are Not To Blame

Many people still carry the misperception that they somehow caused themselves to have these compulsive behaviors and obsessive thoughts. Nothing could be further from the truth. OCD is likely the cause of a number of intertwined and complex factors which include genetics, biology, personality development, and how a person learns to react to the environment around them. What scientists today do know is that it is not a sign of a character flaw or a personal weakness. OCD is a serious mental disorder which is more treatable than ever. It affects a person's ability to function in every day activities, one's work, one's family, and one's social life.

Features Of OCD

Obsessions

Obsessions are unwanted ideas or impulses that repeatedly well up in the mind of a person with OCD. Common ideas include persistent fears that harm may come to self or a loved one, an unreasonable concern with becoming contaminated, or an excessive need to do things correctly or perfectly. Again and again, the individual experiences a disturbing thought, such as, "My hands may be contaminated -- I must wash them" or "I may have left the gas on" or "I am going to injure my child." These thoughts tend to be intrusive, unpleasant, and produce a high degree of anxiety. Sometimes the obsessions are of a violent or a sexual nature, or concern illness. (NIMH)

Compulsions

In response to their obsessions, most people with OCD resort to repetitive behaviors called compulsions. The most common of these are washing and checking (e.g., making sure the gas is off for the oven). Other compulsive behaviors include counting (often while performing another compulsive action such as hand washing), repeating, hoarding, and endlessly rearranging objects in an effort to keep them in precise alignment with each other. Cognitive problems, such as mentally repeating phrases, list making, or checking, are also common. These behaviors generally are intended to ward off harm to the person with OCD or others. Some people with OCD have regimented rituals while others have rituals that are complex and changing. Performing rituals may give the person with OCD some relief from anxiety, but it is only temporary.

courtesy of The National Institute of Mental Health

Treatment of OCD

Psychotherapy

For many years, OCD was seen as a purely psychological disorder, related to a desire to control one's environment or to *undo* some perceived wrong action. Insight oriented psychotherapy has been singularly unsuccessful in treating this group of disorders, however. Behavior therapies have had much more success, especially those with specific small steps geared to the exact obsessions/compulsions involved in the individual case.

Behavior therapy has a lot to offer individuals with this disorder. Two common and popular techniques are **systematic desensitization** and **flooding**. Systematic desensitization techniques involve gradually exposing the client to ever-increasing anxiety-provoking stimuli. It is important to note here, though, that such a technique should **not be attempted until** the client has successfully learned relaxation skills and can demonstrate their use to the therapist. Exposing a patient to either of these techniques without increased coping skills can result in relapse and possible harm to the client. Relaxation techniques may include imagery, breathing skills, and muscle relaxation. It is important for the client to find a relaxation technique which works best for them, before attempting something like systematic desensitization or flooding. Flooding allows the patient to face the most anxiety-provoking situation, while using the relaxation skills learned. Systematic desensitization is the preferred technique of the two; flooding is not recommended except in rare uses. Flooding's potential harm usually outweighs its potential benefits (e.g., traumatizing the individual further).

Additional behavior and cognitive-behavioral techniques which may have some effectiveness for people who suffer from this disorder include **saturation** and **thought-stopping**. Through saturation, the client is directed to do nothing but think of one obsessional thought which they have complained about. After a period of time of concentration on this one thought (e.g., 10-15 minutes at a time) over a number of days (3-5 days), the obsession can lose some of its strength. Through thought-stopping, the individual learns how to halt obsessive thoughts through proper identification of the obsessional thoughts, and then averting it by doing an opposite, incompatible response. A common incompatible response to an obsessive thought is simply by yelling the word "Stop!" loudly. The client can be encouraged to practice this in therapy (with the clinician's help and modeling, if necessary), and then encouraged to transplant this behavior to the privacy of their home. They can also often use other incompatible stimuli, such as tweaking a rubber-band which is around their wrist whenever they have a thought. The latter technique would be more effective in public, for example.

Medications

In the last 25 years, medications have been found to be fairly successful in the treatment of OCD. First was the tricyclic antidepressant clomipramine (Anafranil). This has been followed by several of the newer SSRI class anti-depressants that act selectively on the re-uptake of serotonin, a neurotransmitter. In the last few years, neuro-imaging studies have begun to disclose the underlying pathophysiology of OCD. The area of the brain that functions abnormally is directly next to those areas that relate to tick disorders such as Tourette's Syndrome and to Attention Deficit Disorder. It now seems that variable amounts of dysfunction produce clinical symptoms that may be virtually all in one of these areas, or may be overlapping. Many people with ADD also have tics, as do many people with OCD. Most unexpected is the finding that children who have Rheumatic Fever and develop Sydinham's Chorea have a significantly increased risk of OCD. Therefore treatment with antibiotics early in an infectious illness may reduce the chances of future obsessive thinking.

Summary

Imaging studies have also demonstrated that both medications and behavior therapy alter brain metabolism in the direction of normalcy. This then is one of the few areas in all of mental health where clear proof exists for the efficacy of multiple types of treatment.

With medications, generally the dose used to treat depression is not enough to control OCD symptoms. Patients often will take 2-4 times the amount used to treat depression. Behavioral therapy with medications seems to offer the best long term improvement.

The illness is cyclic, and worsens when the individual is under stress.

As of January, 2001, OCD is considered a Major Mental Illness in California which now entitles it to coverage by the medical portion of most insurance plans, often providing better benefits than those allowed under the regular mental health provisions of the insurance plan.