OBSESSIVE-COMPULSIVE DISORDER

FOR PATIENTS AND FAMILIES

Obsessive-compulsive disorder (OCD) is a psychiatric illness with two essential features: obsessions and/or compulsions. **Obsessions** are recurrent, persistent, and intrusive thoughts, impulses, or images that cause marked anxiety, fear, and distress. The individual is aware that these obsessions are inappropriate and irrational and not simply due to excessive worries from situational problems. The obsessional thoughts, impulses, or images are recognized as originating internally and therefore provoke conflict and anxiety. However, the patient is powerless to control these obsessions. To deal with the internal conflicts, the individual tries to ignore, suppress, or neutralize the intrusive or inappropriate obsessions with other thoughts or actions.

Compulsions are repetitive, purposeful behaviors or mental acts (e.g., praying, counting, or repeating words silently) performed in response to decrease anxiety and distress associated with obsessions or to prevent obsessional thoughts. The individual uses repetitive, ritualistic behavior in attempt to neutralize the anxiety and distress provoked by the obsessions. Each ritual is repeated over and over again until there is some relief of the anxiety and distress. Unfortunately, the relief is temporary because as obsessive thoughts recur, compulsive behaviors are repeated.

DIAGNOSIS

The diagnosis of OCD is made on the basis of a person's having either obsessions *or* compulsions, or both, with symptoms that cause marked anxiety and distress, result in time-consuming rituals, or interfere with the person's normal activities, job, or relationships. During the course of illness, the person (except children) may recognize that the obsessions and compulsive behaviors are irrational, excessive, or inappropriate. However, the person is powerless to control them. The following obsessive and compulsive symptoms are commonly seen in patients with OCD:

- *Fear of contamination*. An excessive obsession or fear of contamination is often present, accompanied by hand washing or other cleaning activity. The symptoms are similar to those of phobias. There is anxiety and fear of dirt, germs, bodily waste or secretions, environmental contamination, animals, insects, and so on. Individuals are often concerned with becoming contaminated by touching objects or people. They may wear gloves to avoid germs or use tissue paper to pick up objects.
- *Washing and cleaning*. An indication of compulsive hand washing may be raw, chafed hands, sometimes to the point where the hands are cracked and bleeding. Individuals may bathe numerous times during the day. These rituals become more frequent and time-consuming as the disorder is exacerbated.
- *Irrational doubt and insecurity*. Individuals may possess obsessive thoughts that something terrible or harmful will happen. Consequently, compulsive activities are performed in response to relieve the anxety and distress. Individuals are compelled to check constantly on their surroundings to feel secure. For example, before leaving the house, they may check all the locks on the doors and windows or other fixtures around the house, such as water faucets, appliances, and electrical switches. They may need to count the number of times that things must be checked, and only after a certain number of times will it be "all right." The time-consuming ritual often causes these individuals to be late for work, school, or appointments.
- *Need for symmetry and precision*. Individuals may have a need to arrange things and events in a precise order or place. Things must be made symmetrical, orderly, and precise. Tasks must be performed in a certain order and done precisely. When things are not in perfect order or alignment, there is discontent and tension.

- *Somatic*. Individuals may have excessive preoccupation with a part of their body, appearance, or developing illness or disease. This excessive somatic preoccupation is similar to that of patients with **hypochondriasis,** but what separates obsessive-compulsive patients is that they have other obsessions and compulsions.
- *Hoarding*. Individuals may collect things, generally of little value, and count and check that nothing is missing or has been thrown out.
- *Religious obsessions*. Individuals may obsess over their religious beliefs and moral values, devoting many hours of the day to ritualistic practices. They may see their suffering as a religious trial and their rituals as an obligation of their religious cause.

There are individuals who have **obsessive-compulsive personality disorder** (OCPD) and not OCD. Although the diagnostic names are similar, these two disorders are different from each other. Individuals with OCPD have a need for perfectionism and orderliness, but they are not out of control and do not experience as much as dysfunction related to obsessions and compulsive behavior as patients with OCD. They may be obstinate about perfectionism, orderliness, and cleanliness, but generally they do not show the compulsive behavior of OCD. In fact, OCPD rarely leads to OCD, bolstering the argument that these disorders are separate entities. Moreover, individuals with OCPD do not respond to medications.

COURSE OF ILLNESS

Typically, OCD begins during the late teens and early twenties, usually between the ages of 19 and 24. It affects males and females almost equally, although males tend to have the illness earlier. Generally, the onset of illness is gradual, but the disorder may develop suddenly, as well. Depression often coexists with OCD, and recurrent depression may be as high as 80% in patients with OCD.

CAUSE OR ETIOLOGY

OCD affects about 1%–2% of the general population. There is strong evidence from family studies that some aspects of the illness are hereditary. Studies have shown that up to 20% of immediate relatives of patients with OCD have obsessive-compulsive symptoms. There also appears to be a genetic relationship between individuals with OCD and Tourette's syndrome, a tic disorder. Children of a parent with Tourette's syndrome are more likely than the average person to develop OCD.

Advancements in the treatment of OCD provide the strongest evidence that the basis of the illness may be biochemical, and not merely behavioral. The biochemical model of OCD is focused on the brain neurotransmitter **serotonin**. Experts believe that OCD may be caused by disturbance in the level of serotonin or by disturbance in areas of the brain involving serotonin. Generally, antidepressants that increase the levels of serotonin in the brain are effective agents for treating OCD.

TREATMENT

Medications

Antidepressants that are effective for treating the symptoms of OCD are those that work by increasing levels of serotonin. These antidepressants include **clomipramine** (Anafranil), tricyclic antidepressants, and the **selective serotonin reuptake inhibitors** (SSRIs), which include **citalopram** (Celexa), **fluoxetine** (Prozac), **fluvoxamine** (Luvox), **escitalopram** (Lexapro), **paroxetine** (Paxil), and **sertraline** (Zoloft). Clomipramine, the first drug marketed for OCD, is associated with frequent side effects that limit its usefulness. The SSRIs are generally better tolerated by patients and are currently the preferred medications for treating OCD. Treating OCD with SSRI antidepressants generally requires higher doses than are used for depression and lengthy trials because the response is often delayed.

Psychotherapy

Behavior therapy, in conjunction with pharmacotherapy, has produced dramatic success in the treatment of OCD. Behavior therapy consists of *exposure* and *response prevention*. The technique of exposure and response prevention requires patients to identify and confront the situation or stimulus that evokes fear or anxiety and then teaches them how to prevent and refrain from the compulsive behavior. For example, the therapist may ask the patient to step on a crack, creating anxiety, and in turn help the individual to learn not to react to the situation. In time, the patient's anxiety dampens and the ritual of avoiding cracks decreases. The therapist may also teach the patient thought-stopping techniques to interrupt the obsessive thoughts once they are triggered.

In the beginning of behavior therapy, there may be periods of considerable fear and anxiety, as the patient attempts to confront the problem. However, patients who persevere with treatment generally have a remarkable rate of improvement.

If you have any questions about this handout, please consult your physician.

SUPPORT AND ADVOCACY GROUPS

Obsessive-Compulsive Foundation, Inc.
676 State Street
New Haven, CT 06511
Phone: (203) 401-2070
Web site: www.ocfoundation.org
Provides education to the public about OCD and related disorders and assistance to patients and family, and supports research into the causes and treatment of OCD and related disorders.

Anxiety Disorders Association of America
8730 Georgia Avenue, Suite 600
Silver Spring, MD 20910
Phone: (240) 485-1001
Web site: www.adaa.org
A nonprofit organization dedicated to promoting the education and awareness of anxiety disorder.