

# **DISCLAIMER**

The information contained within this document does not constitute medical advice or diagnosis and is intended for education and information purposes only. It was current at the time of publication and every effort is made to keep the document up to date.

The information contained herein includes both psychological and non psychological interventions. The delivery of psychological services requires a medical referral whilst non psychological services do not.

Each person is an individual and has a unique psychological profile, biochemistry, developmental and social history. As such, advice will not be given over the internet and recommendations and interventions within this website cannot be taken as a substitute for a thorough medical or allied health professional assessment or diagnosis.

# Obsessive Compulsive Disorder (OCD)

## Article QUICK LINKS :

[Introduction](#) / [Obsessions](#) / [Compulsions](#) / [Current Treatments for OCD](#) / [Pharmacological](#) / [Psychotherapy](#) / [Neurofeedback](#) / [Further Reading Suggestions](#) / [Links](#) / [References](#)

## INTRODUCTION

Obsessive Compulsive Disorder (OCD) usually involves obsessions as well as compulsions, although a person with OCD may sometimes have only one or the other. OCD is also implicated as having a high prevalence of comorbidity with other disorders.

[DSM-IV](#) (The Diagnostic and Statistical Manual published by the American Psychiatric Association) lists OCD among the 'anxiety disorders', with another listing under 'personality disorders'.

It is currently estimated, that as many as 1 in 50 adults has a form of OCD, and twice that number have had it at some point in their lives.

A person is considered as having OCD when obsessive and compulsive behaviours are extreme enough to interfere with the quality of everyday life.

Worries, doubts, and superstitious beliefs are all common in everyday life. However, when they become excessive to the point of hours of hand washing, or make no sense at all, such as driving around and around the block to check that an accident didn't occur, then a diagnosis of OCD is probably in order. In OCD, it is as though the brain gets stuck on a particular track, thought or urge and just can not let go...

## OBSESSIONS

Obsessions are unwanted, persistent thoughts, images, or impulses that occur over and over again and the person will feel that they are out of their control. An OCD person does not want to have these ideas, and finds them disturbing, and intrusive, and usually recognises that they don't really make sense or have relevance to the reality of the situation. People with OCD may worry excessively about dirt and germs and be obsessed with the idea that they are contaminated or may perhaps contaminate others. They may alternatively have obsessive fears of inadvertently harming someone else (for example while driving their car out of the driveway), even though they usually know this is not realistic. Obsessions are accompanied by uncomfortable feelings, such as fear, disgust, doubt, or a sensation that things have to be done in a way that is "just so".

## COMPULSIONS

People with OCD typically try to make their obsessions go away by performing irresistible compulsions. Compulsions are acts that the person performs over and over again, often according to certain "rules". People with an obsession about contamination may wash constantly to the point that their hands become raw and inflamed. A person may repeatedly check that she has turned off the stove or iron because of an obsessive fear of burning the house down. They may have to count certain objects over and over because of an obsession about losing them. Unlike compulsive drinking or gambling, OCD compulsions do not give the person pleasure. Rather, the rituals are performed to obtain relief from the discomfort caused by the obsessions.

OCD like behaviours are present across the mammalian species, suggesting that it may well be a central nervous system disorder. OCD is a brain disorder that causes problems in information processing. At present there are no definitive biological findings diagnostic of OCD. Research however, does suggest that OCD involves problems in communication between the front part of the brain (the orbital cortex) and deeper structures (the basal ganglia). These brain structures use the chemical messenger serotonin. It is believed that insufficient levels of serotonin are prominently involved in OCD.

Recent studies suggests different OCD profiles across subjects. Factor analysis of Yale-Brown Obsessive-Compulsive Scale (Goodman, Price, Rasussen, Mazure, Delgado, et al., 1989) item scores in more than 300 OCDs yielded four factors accounting for more than 60% of total variance: obsessions and checking, symmetry and order, cleaning and washing, and hoarding. (Leckman et al., 1997).

Not all obsessive-compulsive behaviours represent a disorder. Some rituals, like bedtime songs / stories, religious practices, etc., are a welcome part of daily life. People with OCD should not be confused with a much larger group of individuals who are sometimes considered "compulsive" because they hold themselves to a high standard of performance and are 'perfectionists' and very organised in their work and oftentimes, their recreational activities.

This type of "compulsiveness" can serve a valuable purpose, contributing to a person's self-esteem and success at work. In this respect, it differs from the life-disrupting obsessions and rituals of the person with OCD. However, if taken to the extreme, this type of behaviour can become a problem when the ability to enter into and carry out interpersonal relationships (work, personal and social) are affected. This may signal obsessive compulsive personality disorder (OCPD) as distinct from obsessive compulsive anxiety disorder in which a person experiences feelings of dread if the compulsive behaviours are not performed.

Normal worries, such as contamination fears, may increase during times of stress, such as when someone in the family is sick or dying. Only when symptoms of OCD persist, make no sense, cause much distress, or interfere with functioning do they warrant clinical attention. But as in all things, the sooner the interventional programme is begun, the sooner normal function may be regained.

## **Some other considerations concerning obsessive-compulsive disorder...**

OCD behaviours usually cause distress, take up a lot of time (more than an hour a day), or significantly interfere with the person's work, social life, or relationships.

Most individuals with OCD recognise at some point that their obsessions are coming from within themselves and are not just excessive worries about real problems, and that the compulsions they perform are excessive or unreasonable.

When someone with OCD does not recognise that their beliefs and actions are unreasonable, this is *called OCD with poor insight*.

OCD symptoms tend to wax and wane over time. Some may be little more than "background noise"; others may produce extremely severe distress.

Some disorders that closely resemble OCD and may respond to some of the same treatments are trichotillomania (compulsive hair pulling), body dysmorphic disorder (imagined ugliness), and habit disorders, such as nail biting or skin picking. Impulse control problems, such as substance abuse, pathological gambling, or compulsive sexual activity whilst they share many similarities, may prove more intractable.

The most common conditions that resemble OCD are the tic disorders (Tourette's Disorder and other motor and vocal tic disorders). Tics are involuntary motor behaviors (such as facial grimacing) or vocal behaviors (such as snorting) that often occur in response to a feeling of discomfort. More complex tics, like touching or tapping tics, may closely resemble compulsions. Tics and OCD occur together much more often when the OCD or tics begin during childhood.

In his most recent view of the neurobiology of OCD, Stein (1996) submits that "although OCD may be a disorder of the brain, a comprehensive understanding of the condition also requires attention to brain based emergent cognitive-affective structures and processes." We may therefore conclude from Stein's work that an exclusive focus on the neurological or the psychiatric / psychological factors in isolation is simply insufficient.

The following table after Cummings' work on Tourette's syndrome as a spectrum disorder (1990) offers some idea of the key comorbidities and their prevalence:

OCD	68%
Coprolalia (utterances of vulgar or obscene words)	58%
Sleep Disorders	48%
Self-destructive Behaviours	48%
Learning Disorders	40%
PANIC Attacks	33%
Schizoid Behaviours	33%
Speech Problems	32%
Hypersexuality	32%
Phobias	30%
Migraines	27%
Enuresis, encopresis	20%

This study was repeated and supports the view that these conditions correspond with the behaviour related to frontal lobe disorders correlating with serotonergic system abnormalities. viz. depressive mood, emotional lability, perseveration behaviours, compulsion, agitation, anxiety, disinhibition, irrationality, apathy, loss of initiative, depression, general anxiety, panic attack, obsessive-compulsive disorder, aggressiveness, impulsivity, sleep disorders, eating disorders, pain, retardation. (Miller & Cummings, 1999)

Recent regional blood flow studies have shown that there are differences in the orbital prefrontal cortex and the caudate nucleus (Baxter, 1994). Maria and Arvid Carlsson proposed a circuitry analogy in terms of the flow of information and the signalling process within the brain in 1990. In depression and OCD, we are looking then at the overactive circuits that code for negative imagery of self and the world (depression) and fixed behavioural or ideational circuitry (OCD).

Depression and OCD often occur together in adults and, less commonly, in children and adolescents. However, unless depression is also present, people with OCD are not generally sad or lacking in pleasure, and people who are depressed but do not have OCD rarely have the kinds of intrusive thoughts that are characteristic of OCD.

Although stress can make OCD worse, most people with OCD report that the symptoms can come and go on their own. OCD is easy to distinguish from a condition called posttraumatic stress disorder, because OCD is not caused by a terrible event.

Schizophrenia, delusional disorders, and other psychotic conditions are usually easy to distinguish from OCD. Unlike psychotic individuals, people with OCD continue to have a clear idea of what is real and what is not.

In children and adolescents, OCD may worsen or cause disruptive behaviors, exaggerate a pre-existing learning disorder, cause problems with attention and concentration, or interfere with learning at school. In many children with OCD, these disruptive behaviours are related to the OCD and will go away when the OCD is successfully ameliorated.

Individuals with OCD may have substance-abuse problems, sometimes as a result of attempts to self-medicate. Specific treatment for the substance abuse is usually also needed.

Children and adults with pervasive developmental disorders such as autism and Asperger's syndrome are extremely rigid and compulsive, with stereotyped behaviours that somewhat resemble very severe OCD. However, those with pervasive developmental disorders have extremely severe problems relating to and communicating with other people, which do not occur in anxiety related OCD.

You may have noticed that many of the conditions listed may be considered as relative disorders of attention. In OCD for example, the person is over focussed on replaying a behaviour. In ADD the attentional abilities are just dysfunctional and under focussed or non-existent, usually due to immature development of the frontal lobe 'circuits'.

OCD is clearly a broad spectrum disorder requiring expedient intervention appropriate to the unique needs of the individual. Multimodal, interdisciplinary, intensive programmes have often been the most effective means through which a person with OCD can find relief.

## **CURRENT TREATMENTS FOR OCD**

Conventional treatment of OCD includes educating the person and their family about OCD and its management. The most common interventions for OCD are medication and Cognitive-Behavioural Therapy (CBT).

## **PHARMACOLOGICAL**

SSRI's (serotonin reuptake inhibitors) are the drug of choice in the allopathic or disease model of OCD. In Australia, the following drugs are listed in the MIMS as appropriate for treatment of OCD: Anafranil, Aropax, Auscap, DBL Clomipramine, DBL Fluoxetine, Erocap, Fluohexal, Lovan, Luvox, Placil, Prozac, SBPA Fluoxetine, Zactin and Zoloft.

Primarily clomipranine, Paroxetine hydrochloride, Moclobamide, Venlefixine, Amitriptyline, Imipramine, Phelelzine

All are listed in the MIMS as 'anti-depressants' and carry many contraindications and side effect listings. As always, the choice for medication must be weighed through the potential psychological and physical benefits against the side effects produced by the drug. It must also be remembered that titration (dosage) will require some experimentation over time, as each person will react differently to the drug chosen.

## PSYCHOTHERAPY

Cognitive behavioural therapy (CBT) is the psychotherapeutic intervention used with children, adolescents, and adults with OCD. In CBT, people learn to change their thoughts and feelings by first changing their behaviour. Exposure and response prevention are combined to help the person internalize a strategy for resisting obsessions and compulsions. Exposure is generally more helpful in decreasing anxiety and obsessions, while response prevention is more helpful in decreasing compulsive behaviours. Other techniques include thought stopping and distraction (suppressing or "switching off" OCD symptoms), satiation (prolonged listening to an obsession usually using a closed-loop audiotape), habit reversal (replacing an OCD ritual with a similar but non-OCD behaviour), and contingency management (using rewards and costs as incentives for ritual prevention) may sometimes be helpful but are generally less effective than standard CBT.

People react differently to psychotherapy, just as they do to medicine. CBT is relatively free of side effects, but all patients will have some anxiety during treatment. CBT can be done on an individual basis, in a group or with a family.

## NEUROFEEDBACK

Since OCD most closely resembles the tic disorders and may be considered part of the attentional spectrum of disorders, neurofeedback or [EEG biofeedback](#) may be of benefit. Neurofeedback can alter neurochemical systems thus improving arousal and balance of the nervous system. EEG biofeedback first had success with epilepsy in the work of Barry Stermann. Since then, the clinical application of EEG biofeedback has widened to encompass many disorders including Obsessive Compulsive Disorder.

## FURTHER READING SUGGESTIONS

- Neurofeedback - EEG Biofeedback - a Drug-Free Strategy for ADHD, Learning Disorders and Other Conditions

**For more information or to make an appointment please contact us on (02) 9637 9998 during business hours.**

## LINKS

### PLEASE NOTE :

Learning Discoveries offers the links below as a convenience to our clients and the users of this website. However, we do not control third party websites and we are not responsible for the websites content.

- **DSM-IV, By the American Psychiatric Association**

To view the DSM-IV criteria and revisions online please go to:

[http://en.wikipedia.org/wiki/DSM-IV\\_Codes](http://en.wikipedia.org/wiki/DSM-IV_Codes)

DSM-IV is a coded reference manual published by the American Psychiatric Association to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders.

- **ICD-10, By the World Health Organisation**

To view the ICD-10 criteria and revisions online please go to:

<http://apps.who.int/classifications/apps/icd/icd10online/>

The ICD - 10 is a coding of diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization.

## REFERENCES

1. Kimble, D.P., (1992), Biological Psychology, Harcourt Brace, New York, NY.
2. Miller, B.L., Cummings, J.L., (1999), The Human Frontal Lobes, Guilford Press, New York, NY.
3. Evans, J.R., Abarbanel, A., (1999), Quantitative EEG and Neurofeedback, Academic Press, London, UK.
4. Werbach, MR., (1999), Nutritional Influences on Mental Illness, Third Line Press, Tarzana, California.
5. Goodman, W.K., Price, L.H., Rasmussen, S.a., Delgado, P., Henniger, G.R., & Charney, D.s. (1989), The Yale-Brown Obsessive-Compulsive Scale, I: Development, use and reliability. Archives of General Psychiatry, 46(11), 1012-1016.