

Anxiety disorders (Obsessions & Compulsions)

➤ Defining OCD

- Obsessive-Compulsive disorder is one in which a person has recurrent and unwanted thoughts, a need to perform repetitive and rigid actions, or both.
- Obsessions are the recurrent and unwanted thoughts which cause anxiety while compulsions are the repetitive actions done to reduce this anxiety.
- The DSM-IV describes the main symptoms of OCD as:
 - Recurrent obsessions and compulsions
 - Recognition by the individual that the obsessions and compulsions are excessive and/or unreasonable
 - That the person is distressed or impaired, and daily life is disrupted by the obsessions and compulsions.
- Occurs in approx. 2% of the population and in equal numbers in men and women.
- Age of onset- usually adolescence and early adulthood. Could begin in childhood.

➤ Case study- “The boy who could not stop washing” by Dr. Judith L. Rappaport

- 14 yr-old Charles spent 3 hrs in the shower and 2 hrs dressing up
- Thought “stickiness” was terrible and could always feel it.
- Was given Anafranil drug which seemed to make him symptom-free for a year.
- Not completely cured as he developed a tolerance for the drug but only then engaged in this OCD behaviour in the evening so not to disrupt his day.

➤ Measuring OCD- Maudsley obsessive-compulsive inventory (MOCI)

- Developed by Hodgson and Rachman (1977)
- Consists of a 30 item true/false self-report questionnaire
- The scale assesses overt rituals and their related obsessions.
- The questions are divided into 4 sub-scales including:
 - Washing
 - Checking
 - Slowness
 - Doubting

➤ Alternate measure- Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

- Popular measure used in many studies
- 2 parts to the measurement and it is used as a semi-structured interview technique
- Symptom checklist- 67 symptoms for OCD and the interviewer notes whether each symptom is current, past or absent. This helps the interviewer determine whether a group of clustered symptoms exists (the list is divided into groups such as aggressive obsessions, sexual obsessions, contamination obsessions, checking obsessions, ordering compulsions, cleaning/washing compulsions).
- The Y-BOCS itself- 19 items that the interviewee completes during the interview based on responses and observations.
- Score is given out of 20 for obsessions and compulsions separately
- 9 other items are noted on the 1-4 scale for severity
- Children's version of the scale is available
- Explanations of OCD
 - Biomedical explanation
 - Suggests OCD results from abnormal brain structure and/or functioning
 - The brain areas believed to be involved with OCD are the orbitofrontal cortex (OFC) and the thalamus
 - Thalamus function- controlling, checking and other safety behaviours
 - OFC function- decision making and worry about social and other behaviours
 - In OCD, these 2 brain areas are thought to be overactive. An overactive thalamus would result in an increased motivation to clean or check for safety. If the thalamus was overactive, the OFC would become overactive as a result and that would lead to increased anxiety and increased planning to avoid anxiety.
 - According to the biochemical model, OCD could be the result of a serotonin deficiency or a malfunction in its metabolism, for example: blocked serotonin receptors. Joseph Zohar found that some tricyclic drugs that inhibited the re-uptake of serotonin were beneficial for about 60% of his sample of OCD patients. However, Robert Lydiard found that drugs only provided a partial alleviation (reduction) from the symptoms of OCD.

- Also, some studies have found that SSRIs reduce the symptoms of OCD. Example- Gilbert et al (2000) showed that thalamic volumes were significantly greater in treatment-naïve patients with OCD than in controls but declined significantly after paroxetine hydrochloride (SSRI) monotherapy to levels comparable with those of controls. Decrease in thalamic volume in patients with OCD was associated with reduction in OCD symptom severity.
- The findings provide new evidence of thalamic abnormalities in paediatric OCD and further suggest that paroxetine treatment may be paralleled by a reduction in thalamic volume. However, the findings are preliminary given the small sample size and the inability to measure discrete thalamic nuclei.
- Taj et al (2013) researched a candidate gene called DRD4 (dopamine receptor D4). A total of 173 individuals with OCD were compared to 201 healthy controls. They completed a range of questionnaires that measure OCD and mental health and all were genotyped for the DRD4 gene and variants. It was revealed that the 7R allele frequency was higher in the OCD group (especially so for females), suggesting a potential genetic cause for OCD.
- Cognitive-behavioural explanation
 - Cognitive theory proposes that people with OCD have a ‘cognitive bias’ when attending to environmental stimuli. For example, their attenuation system may be *hypervigilant* (excessively careful and watchful).
 - OCD sufferers’ memories may also be impaired so they do not remember having done the action thus causing them to repeat it.
 - They may try to suppress their obsessive thoughts which just make them more likely, leading them to perform the compulsion. Performing the compulsion reduces anxiety and this is rewarding and therefore acts as a positive reinforcement and encourages them to repeat the behaviour.
 - Rachman (2004) outlines a case study of a patient with OCD that gives a good account of hypervigilance. A female patient has a severe fear of diseases, particularly the prospect

of encountering other people's blood. She had catastrophic thoughts about the probability of harm (e.g. contracting AIDS) coming from even a small plaster worn by someone. She over-estimated the seriousness of contact with anyone. When she went to a public place, she rapidly scanned the environment and the people she encountered, constantly on the lookout for evidence of blood, cuts, bandages etc. She tended to misperceive as blood a wide range of dark-coloured spots and her hypervigilant scanning meant that she could recall in great detail the blood-related items that she had encountered over many years.

○ Psychodynamic explanation

- OCD is caused by instinctual forces (driven by the id in the unconscious) that are not under full control due to traumatic experiences in the anal stage of psychosexual development. The person with OCD is therefore fixated in the anal stage of psychosexual development.
- It is the battle between the id's desires and the superego's morals that can cause OCD as the ego (and its defence mechanisms) are overwhelmed.
- Obsessive thoughts may be generated by the id (e.g. to be messy and out of control) but the ego uses defence mechanisms to counteract this by making the person behave in a way that is completely opposite to that (e.g. being neat and tidy). This defence mechanism is called reaction formation.
- For example, if a child has had a traumatic experience while potty training (e.g. if the child is harshly treated for being messy) then the obsessive thoughts of being neat and tidy re-emerge in adolescence and adulthood. The person develops OCD as a result because of those early unresolved traumatic experiences. [Anal-retentive personality]

➤ Treatments for OCD

○ Drug therapy

- In the 1960s, a drug called Anafranil (clomipramine) was used (e.g. on Charles) which belongs to the class of medications known as tricyclic antidepressants. They are said to bring about a balance in certain neurotransmitters

such as serotonin. However, it had several side-effects such as changes in sexual ability, weight gain, fatigue and seizures.

- Other antidepressants were also used that seemed to improve symptoms such as paroxetine (Gilbert et al, 2000).
- SSRIs such as Prozac and paroxetine are more effective than antidepressants that do not interact with the serotonin uptake pump. So although SSRIs can be used to treat depression, all antidepressants cannot be used to treat OCD. This specificity supports the idea that OCD is rooted in chemical imbalance.
- Improvement is found in between 50% and 80% of cases of drug therapy (Julien 2005). The obsessions and compulsive behaviours do not fully disappear, but are greatly reduced. This allows the person to adopt a much more normal life, where obsessive thoughts and compulsive behaviours do not dominate on a regular, daily basis.

○ CBT

- This therapy attempts to change the conscious thought processes. There are two initial steps involved.
 - Helping people to understand that they are misinterpreting their thoughts – misinterpretations include, thinking that the thought will become an actual behaviour, and feeling guilty and ashamed about having obsessive thoughts.
 - Making people aware of how they try to neutralise the obsessive thoughts by attempting to make amends for having such thoughts.
- Once these 2 steps have been achieved, the therapist moves on to helping the person change their distorted cognitive processes. The most important aspect here is to stop the person from **catastrophising**. The approach attempts to either remove the obsessive thoughts or get the person to think about them in a different way. (What's the worst that could happen if you don't give into your compulsion?)
- Both approaches are done to help the person stop performing the compulsive behaviours. An additional techniques used in cognitive therapy is **habituation training** (Franklin et

al 2000). Here the client is asked to think repeatedly about their obsessive thoughts. The idea is that by deliberately thinking about obsessions, they will become less anxiety raising, with the consequence that compulsive behaviour is not required to reduce high levels of anxiety.

- Research has shown that cognitive therapy is successful in reducing the frequency with which people have obsessive thoughts. It has also seems to be effective in reducing both the frequency and the duration of compulsive behaviours (Rufer et al 2005).
- For people who experience obsessions only, habituation training is often the entire plan of treatment (**Rachman and Hodgson, 1989**). For others, however, therapists may add **covert – response prevention**: they teach clients to prevent or distract themselves from carrying out compulsive actions that may occur during habituation training.

★ Cognitive treatment like those given above can often be paired with a more behavioural strategy such as ERP. ERP focuses only on the compulsions, whereas cognitive therapy tends to focus more on the obsessions (so together they are well matched). ERP deliberately exposes clients to objects or situations that cause anxiety and requires the client to resist performing the compulsive behaviour. The role of the therapist is to help the person develop ways in which they can resist performing the compulsive behaviours. A number of steps are usually involved:

1. Informing the client about exposure and response prevention, and what the therapy will involve.
2. Using what is called an exposure hierarchy, which starts with mildly anxiety-raising situations and goes through to the highest level of anxiety (similar to systematic desensitisation)
3. Repeated exposure to situations that cause high anxiety, until the level of anxiety reduces.
4. Getting the client to resist and refrain from performing the compulsive behaviour.

ERP has been used in both one-to-one and group therapy sessions. Outside the therapy session, clients are asked to practise exposing themselves to feared situations and refraining from the compulsive behaviour.

Research which has followed by clients after ERP therapy has shown that between 55% and 75% show improvement and that the improvement lasts for 5 or 6 years (Franklin et al 2005).

- Psychoanalytic therapy
 - The techniques of free association and dream analysis are used in an attempt to uncover the unconscious conflicts that have occurred during the anal and phallic stages of development. Psychodynamic therapy tries to get at the underlying cause of the disorder. It is assumed that the obsessive-compulsive symptoms will disappear once the conflicts have been brought to consciousness and analysed.
 - Example- Rat man (Freud, 1907)
 - Leichsenring et al (2008) examined the long term effectiveness of using psychoanalytic therapy with OCD patients. The researchers reported that long-term psychoanalysis was associated with a significant reduction in the OCD symptoms reported by patients and this was still seen one year after treatment has ended.