

The Priory Group

What is obsessive-compulsive disorder?

by Dr David Veale

*Dr Veale is a Consultant Psychiatrist at the Priory Hospital North London and the co-author of *Overcoming Obsessive Compulsive Disorder* (Veale, D. and Willson, R., Constable and Robinson, 2005)*

What is obsessive compulsive disorder?

OCD is a condition consisting of obsessions or compulsions, or, more commonly, both. This is nothing to do with addictions to gambling, alcohol, exercise or eating, for example, which are quite different. OCD symptoms are never pleasurable and are usually aimed at preventing harm.

What is meant by “obsessions”?

Obsessions are recurrent thoughts, images or urges that people may regard - at least initially - as intrusive and senseless. Later, they find them distressing and feel anxious or guilty.

The most common obsession concerns contamination - of objects or people - from germs, dirt, disease, or radiation, resulting in excessive hand washing or cleaning.

Obsessions can also arise from the fear of causing accident, injury, or misfortune – leaving the house unlocked or the gas taps on for example. Sufferers feel compelled to check repeatedly. Obsessions concerned with violence, murder, blasphemy or sex are also associated with the fear of causing harm. Even if it is difficult to put an obsession into words, people with OCD may find themselves avoiding a wide range of situations or activities to prevent triggering the obsession.

People may also experience obsessions as thoughts, compelling them to perform rituals in their head. These are called ruminations or mental rituals, which neutralise unpleasant thoughts or images.

It is not uncommon for a person to feel demoralized and ashamed of their symptoms, or to become clinically depressed.

What is a compulsion?

Compulsions, or rituals, are actions people feel driven to repeat purposefully to avoid or reduce discomfort. The most common compulsions are:

- Frequent checking to prevent a feared danger
- Excessive cleaning or hand washing
- Repeated assurance seeking
- Repeated counting or touching to prevent disaster
- Arranging or ordering objects or activities, leading to slowness
- Repeated questioning of or confessing to others
- Hoarding of useless or worn-out possessions

What causes OCD?

There are both psychological and biological explanations for OCD. Some families may be genetically predisposed to emotional disorders. Life events or other stress may shape an individual and trigger the onset. Once OCD has developed, the brain tries too hard to regulate its threat system. People with OCD typically have a strong sense of responsibility and overestimate the degree to which they can prevent harm. This is often combined with a tendency to catastrophise and demand certainty or guarantees that bad things won't happen. Sufferers learn to avoid situations and to carry out compulsions that perpetuate their condition.

The rituals may seem mad, but the person performing them is not. They are probably very aware of the absurdity of their behaviour, but have difficulty controlling it. They may be very secretive and reluctant to seek help if they fear that others will think them mad.

When is the onset of OCD most prevalent?

OCD can develop in a child, but it usually appears in teens or twenties. Many people wait years before seeking treatment. About 2% of the population has OCD and it is slightly more common for women than men.

Severe OCD can make regular employment or family life impossible. Those in work or with family responsibilities would almost certainly find life more productive and satisfying without the symptoms. Family members may also become involved in the rituals and suffer greatly.

What are the treatment options available for OCD?

Treatment can improve the outcome of the illness for most sufferers. Mild OCD tends to improve over time without treatment. The outcome is much less predictable for those with moderate to severe OCD. Some may be chronically ill but find they have periods of remission. Others deteriorate progressively.

Two main treatments can definitely be of benefit: Cognitive Behaviour Therapy (CBT), the treatment of choice, and anti-depressant medication. There is no evidence that other psychotherapies, such as psychodynamic or analytical therapy or hypnotherapy, is of any benefit in OCD.

CBT is based first on a psychological understanding of the patient's OCD and what keeps the problem going. The therapist helps to change the excessive degree of responsibility and thought processes, demands for guarantees about the risks of exposure and the criteria used for termination of a compulsion.

When ready to test out which theory best fits the facts, people with OCD may confront whatever they fear (a process called "exposure" or a "behavioural experiment") without performing a ritual ("response prevention"). This means learning to give up control, to resist the compulsion and to tolerate repeatedly the discomfort that occurs. Facing up to the fear gradually gets easier as does coping with the anxiety.

Patients begin by confronting easier situations and then gradually work up to more difficult ones. They may feel anxiety and distress in the short-term, but these tend gradually to decrease. Of those that do adhere to a programme, about 75% are helped significantly. The risk of relapse after treatment is about 25% - in which case, additional treatment may be needed.

Anti-obsessional medication consists of anti-depressants which are strongly "serotonergic" called SSRIs. They may be used either alone or in combination with CBT. Side effects tend to be minor, and fade after a few weeks. The drugs are not addictive and can be stopped at any time without withdrawal symptoms, provided the dosage is reduced slowly. About 60% of patients with OCD improve with medication. Of those, at least 75% will relapse in the months after stopping the drug. Combining the medication with CBT can minimize the risk of relapse. Medication can help depressed patients with their motivation, so

that they are able to take advantage of a psychological treatment programme. It can also reduce excessive anxiety, which can interfere with completion of a course of CBT. For severe OCD, a combination of CBT and a SRRI is recommended. Intensive treatment can also be provided on a residential or inpatient unit.