



Did you know that... Psychology works for Obsessive Compulsive Disorder (OCD)

What is Obsessive Compulsive Disorder?

Have you ever had a strange or unusual thought just pop into your mind that is entirely out of character for you? Maybe you've had the thought of suddenly blurting out an embarrassing or rude comment, or of causing harm or injury to another person, or of doubting whether you acted correctly in a particular situation. Have you had an irresistible urge to do something that you know is entirely senseless, like checking the door even though you know it is locked, or washing your hands even though they are clean? Most people experience unwanted, even somewhat bizarre or disgusting thoughts, images and impulses from time to time. We don't feel upset by these thoughts and urges, even though they seem pretty unusual for our personality and our experience.

Some individuals, however, suffer with a special type of unwanted thought intrusion called **obsessions**. Obsessions are recurrent and persistent intrusive thoughts, images or impulses that are unwanted, personally unacceptable and cause significant distress. Even though a person tries very hard to suppress the obsession or cancel out its negative effects, it continues to reoccur in an uncontrollable fashion. Obsessions usually involve upsetting themes that are not simply excessive worries about real-life problems but instead are irrational concerns that the person often recognizes as highly unlikely, even nonsensical. The most common obsessional content involve (a) contamination by dirt or germs, (b) losing control and harming oneself or other people, (c) doubts about one's verbal or behavioral responses, (d) repugnant thoughts of sex or blasphemy, (e) deviations from orderliness or symmetry, (f) the possibility of sudden sickness (e.g., fear of vomiting), or (g) the need to save even the most useless objects.

Compulsions are repetitive, somewhat stereotypic behaviours or mental acts that the person performs in order to prevent or reduce the distress or negative consequences represented by the obsession. Individuals may feel driven to perform the compulsive ritual even though they try to resist it. Typical compulsions include repetitive and prolonged washing in response to fears of contamination, repeated checking to ensure a correct response, counting to a certain number or repeating a certain phrase in order to cancel out the disturbing effects of the obsession. Over 90% of people with clinical OCD have both obsessions and compulsions, with 25% to 50% reporting multiple obsessions.

Approximately 1% to 2% of the Canadian population will have an episode of OCD, with the possibility that slightly more women experience the disorder than men. The majority of individuals report onset in late adolescence or early adulthood, with very few individuals experiencing a first onset after 40 years of age. OCD is also seen in childhood and adolescence where it has a similar symptom

pattern to that seen in adults. OCD tends to be a chronic condition with symptoms waxing and waning in response to life stresses and other critical experiences. It is uncommon for individuals to spontaneously recover from OCD without some form of treatment.

Depending on the severity of the symptoms, OCD can have a profound negative impact on functioning. In severe cases, obsessive thoughts and repetitive, compulsive rituals can consume one's entire day. Like other chronic anxiety disorders, OCD often interferes with jobs and schooling. Social functioning may be impaired and relationships can be strained as family and close friends get drawn into the individual's OCD concerns.

The actual cause of this disorder is not well known. Genetic factors may play a role but to date there is little evidence of a specific inheritance of OCD. Studies have suggested there may be some abnormalities in specific regions or pathways of the brain. Other research indicates that critical experiences or personality predispositions might be related to increased susceptibility for OCD. However, there is no known single cause to OCD. Instead, most of the genetic, biological and psychological causes probably increase susceptibility to anxiety in general rather than to OCD in particular.

What Psychological Approaches are used to treat OCD?

Since the early 1970s research has shown that **behaviour therapy** is the most effective treatment for most types of OCD. It involves experiencing the fearful situations that trigger the obsession (exposure) and taking steps to prevent the compulsive behaviours or rituals (response prevention). These studies have shown that 76% of individuals who complete treatment (13-20 sessions) will show significant and lasting reductions in their obsessive and compulsive symptoms. When measured against other treatment approaches such as medication, behaviour therapy most often produces stronger and more lasting improvement. In fact, there may be little advantage to combining behaviour therapy and medication given the strong effects of the psychological treatment.

However, up to 30% of people with OCD will refuse behaviour therapy or drop out of treatment prematurely. One of the main reasons for this is a reluctance to endure some discomfort that is involved in exposure to fearful situations. As well, certain types of OCD such as hoarding or rumination without overt compulsion may not respond as well to behaviour therapy.

More recently, psychologists have been adding cognitive interventions to the behaviour therapy treatments involving exposure and response prevention. Referred to as **cognitive behaviour therapy**, this approach helps people change their thoughts and beliefs that may be reinforcing obsessive and compulsive symptoms. Together with exposure and response prevention, this new approach has been shown to be effective in offering hope to individuals suffering from OCD.

Symptoms of OCD¹

- Presence of obsessions and/or compulsions
- Person recognizes that the obsessions or compulsions are excessive, unrealistic, even senseless, at some point during the course of the disturbance
- Obsessions and compulsions cause marked distress, are time consuming, or significantly interfere in daily activities
- The content of the obsessions and compulsions is not restricted to concerns associated with another psychological disturbance such as the preoccupation with food in an eating disorder or guilty ruminations in major depression, nor are the symptoms directly caused by the physiological effects of a substance or general medical condition.

¹Based on the diagnostic criteria of OCD as found in the *Diagnostic and Statistical Manual of Mental Disorders* (4th Ed.) of the American Psychiatric Association (1994).

Resources

- Anxiety Disorders Association of Canada
<http://www.anxietycanada.ca/English.htm>
- Anxiety Disorders Association of British Columbia <http://www.anxietybc.com/>

Other Helpful Resources

- Baer, L. (2000). *Getting Control: Overcoming Your Obsessions and Compulsions* (rev. ed.) New York, Plume.
- De Silva, P. & Rachman, S. (1992). *Obsessive Compulsive Disorder: The Facts*. Oxford: Oxford University Press.
- Foa, E. B., & Kozak, M. J. (1997). *Mastery of Obsessive-Compulsive Disorder: Client Workbook*. San Antonio, TX: The Psychological Corporation.
- Steketee, G., & White, K. (1990). *When Once is not Enough: Help for Obsessive Compulsives*. Oakland, CA: New Harbinger Publications.
- Website of The Obsessive Compulsive Foundation (www.ocfoundation.org)

Consultation with or referral to a registered psychologist can help guide you as to the use of these therapies. For a list of psychologists in your area, <http://www.cpa.ca/Psychologist/>.

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