CHAPTER – I

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This thesis deals with the research carried out to find out the effect of cognitive behavior therapy on Obsessive Compulsive Disorder. This chapter deals with the understanding and information regarding basics of Obsessive Compulsive Disorder and different symptom patterns, Cognitive Behavior Therapy, interventions, different techniques, available treatment approaches, pharmacotherapy, support therapy, family support therapy, other therapies useful to treat this illness. It is an overview of the definitions, meanings, and other theoretical aspects of the concepts included in this study.

In India, the rate of Obsessive Compulsive disorder is increasing day by day. Hence focus on treatment and researches on this topic are today’s requirement. Obsessive-compulsive disorder Obsessive Compulsive Disorder is not an uncommon psychological problem. Obsessive Compulsive Disorder is a brain disorder and the exact cause is not well understood, but imbalances in the neurotransmitter systems of the brain and malfunctioning of certain areas in the brain may lead to recurring thoughts and behaviors that are often seen in Obsessive Compulsive Disorder. Obsessive Compulsive Disorder affects not just the patient but also the entire family. Because of elaborate compulsions, functioning of entire family gets affected. Since Obsessive Compulsive Disorder is a treatable condition, it is essential that families understand their role, where to seek help and how they can help. They should understand some facts of Obsessive Compulsive Disorder i.e. it is a medical problem and thus there is nothing to be ashamed or afraid of to seek treatment. Obsessive Compulsive Disorder is not caused by family dynamics, parenting style or childhood trauma. Stress by itself does not cause Obsessive Compulsive Disorder. Obsessive Compulsive Disorder, particularly when mild, may be dismissed as just an oddity or a simple habit problem, which disappears over time. Parents often tend to accommodate such behaviors because the child demands them to perform certain rituals or reassure
him/her that everything is fine. Accommodation and participation in child’s rituals may exacerbate Obsessive Compulsive Disorder. While some parents are accommodative, others tend to be very critical, dismissive and show lack of understanding of the child’s problem. It is important to learn about common symptoms of Obsessive Compulsive Disorder and how to recognize them. A good understanding of what causes Obsessive Compulsive Disorder, what triggers or worsens Obsessive Compulsive Disorder, and availability of various treatment options is essential to fight Obsessive Compulsive Disorder. For pharmacological treatment by medication you need to consult a psychiatrist. For psychological treatment you need to consult a clinical psychologist. The psychologist can teach alternate ways of thinking which in turn can change the way patient behaves, thereby reducing the Obsessive Compulsive Disorder symptoms.

1.1 OBSESSIVE-COMPULSIVE DISORDER

1.1.1 Introduction

Obsessive Compulsive Disorder is an intriguing and disabling illness characterized by the presence of obsessions (unwanted thoughts, images or impulses) and/or compulsions (repetitive behavior) (Khanna et al, 1990). As recently as in the 1980s, Obsessive Compulsive Disorder was considered to be a rare disorder that was hardly responsive to treatment. Much of the progress in understanding the Obsessive Compulsive Disorder has occurred following the finding of the National Epidemiological Catchment Area (ECA) survey (Karno et al, 1988) that Obsessive Compulsive Disorder is the fourth most common psychiatric disorder. An important additional impetus to the increased interest in diagnosing Obsessive Compulsive Disorder is the availability of effective treatments. However, despite the high prevalence only a minority of the sufferers seeks professional help because of the secretive nature of the illness. Those who suffer from Obsessive Compulsive Disorder often find it embarrassing to talk about their unwanted thoughts resulting in considerable delay in seeking treatment. By the time medical help is sought, many years of illness would have elapsed. Even after starting with pharmacotherapy they fail to adhere to treatment due to lack of knowledge about disorder. Hence with the help of
Cognitive Behavior Therapy they understand the illness, the course and prognosis and the importance of treatment continuation. This leads to better outcome.

The essential feature of obsessive-compulsive disorder (Obsessive Compulsive Disorder) is the symptom of recurrent obsessions or compulsions sufficiently severe to cause marked distress to the person. The obsessions or compulsions are time consuming and interfere significantly with the person’s normal routine, occupational functioning, usual social activities, or relationships. A patient with Obsessive Compulsive Disorder may have an obsession or a compulsion or both.

An obsession is a recurrent and intrusive thought, feeling, idea or sensation. In contrast to an obsession, which is a mental event, a compulsion is a behavior. Specifically, a compulsion is a conscious, standardized, recurrent behavior, such as counting, checking or avoiding. A patient with Obsessive Compulsive Disorder realizes the irrationality of the obsession and experiences both the obsession and the compulsion as ego-dystonic (i.e. unwanted behavior).

Although the compulsive act may be carried out in an attempt to reduce the anxiety associated with the obsession, it does not always succeed in doing so. The completion of the compulsive act may not affect the anxiety, and it may even increase the anxiety. Anxiety is also increased when a person resists carrying out a compulsion.

Historical background and current nosography shows that Obsessive thoughts and compulsive urges or actions are part of everyday life. We return to check that we locked a door and switched off the light. We cannot stop thinking about the stressful event scheduled for the next week. We refuse to eat with the spoon that dropped on the floor, even if we know the chance of contamination is remote. These events are part of the normal feedback and control loop between our thoughts and our actions, and they have an ancestral biological survival value. It is only when obsessive thoughts become frequent or intense, or unavoidable, or when these compulsive rituals become so prominent that they interfere with an individual's functioning, that the diagnosis of Obsessive Compulsive Disorder is made.
Descriptions of the phenomena of obsessions and compulsions can be found in historical documents over the past several centuries, since Obsessive Compulsive Disorder has a long history. A passage from the Malleus Maleficarum, the 15th century compendium of witchcraft and psychopathology, describes a priest brought to Rome for exorcism: 'when he passed any church, and genuflected in honor of the Glorious virgin, the devil made him thrust his tongue far out of his mouth when he tried to engage in prayer, [the devil] attacked him more violently'. Those with obsessive thoughts of a blasphemous or sexual nature were thought to be partially possessed by the devil, while 'psychotic' individuals appeared fully possessed. Obsessions and hand-washing rituals resulting from guilt were immortalized in the 17th century by the Shakespeare character Lady Macbeth: ‘it is an accustomed action with her, to seem thus washing her hands. I have known her continue with this a quarter of an hour’ (Macbeth, V.i.28, describing the time-wasting characteristic of Obsessive Compulsive Disorder).

With time, the explanation for obsessions and compulsions moved from a religious view to a medical one. Esquire first described obsessions and compulsions in the psychiatric literature in 1838, and, by the end of the 19th century, they were generally regarded as manifestations of melancholy or depression. By the beginning of the 20th century, the view of obsessive-compulsive phenomena had begun to shift Obsessive Compulsive Disorder toward a psychological explanation; Janet had already described the successful treatment of compulsive rituals with what would come to be known behavioral techniques, and with Freud's publication in 1909 of the psychoanalysis of a case of obsessional neurosis (the Rat Man), obsessive and compulsive actions came to be seen as the results of unconscious conflicts and the isolation of thoughts and actions from their emotional components. Although this shift succeeded in pointing out that actions can be motivated by factors of which the individual is unaware or unable to control, it did little to improve the outcome of patient’s symptoms. In the 1950s, with the rise of behavioral therapy, the learning theories that had proved to be helpful in the conceptualization and treatment of phobic disorders were applied to Obsessive Compulsive Disorder symptoms. Although these learning theories are clearly insufficient to account for all Obsessive Compulsive Disorder symptoms, they did lead
to the development in the late 1960s and early 1970s of effective treatments for reducing compulsive rituals. During the 1980s, research focused on the relationship of Obsessive Compulsive Disorder and neurological problems such as epilepsy, memory disorders and Tourette's syndrome while Westphal's early observation of an association between obsessions, tic disorders and epilepsy already presaged recent neurobiological findings in Obsessive Compulsive Disorder. Obsessive Compulsive Disorder and OCRDs may also have common manifestations and, since the 1990s, they have therefore been conceptualized with a broad spectrum of related disorders.

Traditionally, Obsessive Compulsive Disorder is described as a condition in which patients have good insight into their symptoms. The DSM-IV field trial demonstrated a broad range of insight with 30% having poor insight. Subsequent studies have also reported poor insight in 15-36% of patients with Obsessive Compulsive Disorder. The DSM-IV has added a new Obsessive Compulsive Disorder specifier: "With poor insight" which involves a lack of recognition that the symptoms are unreasonable or excessive. There is paucity of data regarding the clinical correlates and treatment response of poor insight in Obsessive Compulsive Disorder. A significant limitation of most of the studies is that they did not use validated measure of insight. Only one study used the Brown Assessment of Beliefs Scale (BABS) developed specifically to assess insight. In a recent Indian study, demographic and clinical correlates of poor insight Obsessive Compulsive Disorder, and the association between response to specific serotonin reuptake inhibitors (SSRIs) and baseline insight was examined in a sample of 100 DSM-IV Obsessive Compulsive Disorder subjects by using the BABS a measure of insight. The sample had 25 subjects with poor insight and the remaining 75 had good insight. Those with poor insight had earlier age-at-onset, more severe illness, higher Comorbidity rate particularly major depression, over representation of miscellaneous obsessions and hoarding and poorer treatment response. The study suggests that Obsessive Compulsive Disorder with poor insight could be a distinct subtype. That a significant proportion of Obsessive Compulsive Disorder patients have poor insight has important treatment implications. Patients with poor insight could easily get misdiagnosed as psychotic and treated accordingly. The study suggests that drug treatment response is poor in those with poor insight. The finding is in sharp contrast to
the findings of a previous study that reported that degree of insight at baseline did not predict response to sertraline. It is clinically pertinent to examine if poor insight patients do better with addition of neuroleptics. There is, however, no evidence as yet to suggest that those with poor insight respond better to augmentation with antipsychotics. On the other hand, a few studies have shown that insight improves after treatment with SSRIs.

1.1.2 Epidemiology

The lifetime prevalence of Obsessive Compulsive Disorder in the general population is estimated at 2 to 3 percent. Some researchers have estimated that the disorder is found in as many as 10 percent of outpatients in psychiatric clinics. These figures make Obsessive Compulsive Disorder the fourth most common psychiatric diagnosis after phobias, substance-related disorders, and major depressive disorder. Epidemiological studies in Europe, Asia, and Africa have confirmed these rates across cultural boundaries.

Among adults, men and women are equally likely to be affected, but among adolescents, boys are more commonly affected than girls. The mean age of onset is about 20 years, although men have a slightly earlier age of onset (mean about 19 years) than women (mean about 22 years). Overall, the symptoms of about two thirds of affected persons have an onset before age 25, and the symptoms of fewer than 15 percent have an onset after age 35. The onset of the disorder can occur in adolescence or childhood, in some cases as early as 2 years of age. Single persons are more frequently affected with Obsessive Compulsive Disorder than are married persons, although this finding probably reflects the difficulty that persons with the disorder have maintaining a relationship. Obsessive Compulsive Disorder occurs less often among blacks than among whites, although access to health care rather than differences in prevalence may explain the variation.
1.1.3 Comorbidity

Person with Obsessive Compulsive Disorder is commonly affected by other mental disorders. The lifetime prevalence for major depressive disorder in persons with Obsessive Compulsive Disorder is about 67 percent and for social phobia, about 25 percent. Other common co morbid psychiatric diagnoses in patients with Obsessive Compulsive Disorder include alcohol use disorders, generalized anxiety disorder, specific phobia, panic disorder, eating disorders, and personality disorders. The incidence of Tourette’s disorder in patients with Obsessive Compulsive Disorder is 5 to 7 percent, and 20 to 30 percent of Obsessive Compulsive Disorder patients have a history of tics.

1.1.4 Etiology

- Biological Factors

  - Neurotransmitters. SEROTONERGIC SYSTEM. The many clinical drug trials that have been conducted support the hypothesis that dysregulation of serotonin is involved in the symptom formation of obsessions and compulsions in the disorder. Data show that serotonergic drugs are more effective than drugs that affect other neurotransmitter systems, but whether serotonin is involved in the cause of Obsessive Compulsive Disorder is not clear. Clinical studies have assayed cerebrospinal fluid (CSF) concentrations of serotonin metabolites (e.g., 5-hydroxyindoleacetic acid {5-HIAA}) and affinities and numbers of platelet-binding sites of tritiated imipramine (Tofranil), which binds to serotonin reuptake sites, and have reported variable findings of these measures in patients with Obsessive Compulsive Disorder. In one study, the CSF concentration of 5-HIAA decreased after treatment with clomipramine (Anafranil), focusing attention on the serotonergic system.

  - NORADRENERGIC SYSTEM. Currently, less evidence exists for dysfunction in the noradrenergic system in Obsessive Compulsive Disorder. Anecdotal reports show some improvement in Obsessive Compulsive Disorder
symptoms with use of oral clonidine (Catapres), a drug that lowers the amount of norepinephrine released from the presynaptic nerve terminals.

- **NEUROIMMUNOLOGY.** There has been some interest in a positive link between streptococcal infection and Obsessive Compulsive Disorder. Group A hemolytic streptococcal infection can cause rheumatic fever, and approximately 10 to 30 percent of the patients develop Sydenham’s chorea and show obsessive-compulsive symptoms.

- **BRAIN-IMAGING STUDIES.** Neuroimaging in Obsessive Compulsive Disorder patients has produced converging data implicating altered function in the neurocircuitry between orbitofrontal cortex, caudate, and thalamus. Various functional brain-imaging studies – for example, positron emission tomography (PET) – have shown increased activity (e.g., metabolism and blood flow) in the frontal lobes, the basal ganglia (especially the caudate), and the cingulum of patients with Obsessive Compulsive Disorder. The involvement of these areas in the pathology of Obsessive Compulsive Disorder appears more associated with corticostriatal pathways than with the amygdale pathways that are the current focus of much anxiety disorder research. Pharmacological and behavioral treatments reportedly reverse these abnormalities. Data from functional brain-imaging studies are consistent with data from structural brain-imaging studies. Both computed tomographic (CT) and magnetic resonance imaging (MRI) studies have found bilaterally smaller caudate in patients with Obsessive Compulsive Disorder. Both functional and structural brain-imaging study results are also compatible with the observation that neurological procedures involving the cingulum are sometimes effective in the treatment of Obsessive Compulsive Disorder patients. One recent MRI study reported increased T1 relaxation times in the frontal cortex, a finding consistent with the location of abnormalities discovered in PET studies.
Figure No. 1.1 Positron emission tomography with and without Obsessive Compulsive Disorder. The arrow points to heightened activity, indicated by more grey in brain areas affected by Obsessive Compulsive Disorder, such as the orbital-frontal cortex.

- **Genetics:** Available genetic data on Obsessive Compulsive Disorder support the hypothesis that the disorder has a significant genetic component. The data, however, do not yet distinguish the heritable factors from the influence of cultural and behavioral effects on the transmission of the disorder. Studies of concordance for the disorder in twins have consistently found a significantly higher
concordance rate for monozygotic twins than for dizygotic twins. Family studies of these patients have shown that 35 percent of the first-d egrees relatives of Obsessive Compulsive Disorder patients are also afflicted with the disorder.

- **Other Biological Data:** - Electrophysiological studies sleep electroencephalogram (EEG) studies, and neuroendocrine studies have contributed data that indicate some commonalities between depressive disorders and Obsessive Compulsive Disorder. A higher than usual incidence of nonspecific EEG abnormalities occurs in patients with Obsessive Compulsive Disorder. Sleep EEG studies have found abnormalities similar to those in depressive disorders, such as decreased rapid eye movement latency. Neuroendocrine studies have also produced some analogies to depressive disorders, such as nonsuppression on the dexamethasone-suppression test in about one third of patients and decreased growth hormone secretion with clonidine infusions.

As mentioned above, studies have suggested a possible link between a subset of Obsessive Compulsive Disorder cases and certain types of motor tic syndromes (i.e., Tourette’s disorder and chronic motor tics). There is a higher rate of Obsessive Compulsive Disorder, Tourette’s disorder, and chronic motor tics in relatives of Tourette’s disorder patients than in relatives of controls, whether or not they had Obsessive Compulsive Disorder. Most family studies of probands with Obsessive Compulsive Disorder have found increased rates of Tourette’s disorder and chronic motor tics only among the relatives of probands with Obsessive Compulsive Disorder who also have some form of tic disorder. These data suggest a familial, and perhaps genetic, relationship between Tourette’s disorder and chronic motor tics and some cases of Obsessive Compulsive Disorder.
Figure No. 1.2 Illustration showing the location of the key structures of the brain that play a part in Obsessive Compulsive Disorder.

➢ **Behavioral Factors**

According to learning theorists, obsessions are conditioned stimuli. A relatively neutral stimulus becomes associated with fear of anxiety through a process of respondent conditioning by being paired with events that are noxious or anxiety producing. Thus, previously neutral objects and thoughts become conditioned stimuli capable of provoking anxiety or discomfort.

Compulsions are established in a different way. When a person discovers that a certain action reduces anxiety attached to an obsessive thought, he or she develops active avoidance strategies in the form of compulsions or ritualistic behaviors to control the
anxiety. Gradually, because of their efficacy in reducing a painful secondary drive (anxiety), the avoidance strategies become fixed as learned patterns of compulsive behaviors. Learning theory provides useful concepts for explaining certain aspects of obsessive-compulsive phenomena – for example, the anxiety–provoking capacity of ideas not necessarily frightening in them and the establishment of compulsive patterns of behavior.

**Figure No. 1.3 The Sequence of Obsessive Compulsive Disorder symptoms.**

- **Psychosocial Factors**

Personality Factors. Obsessive Compulsive Disorder differs from obsessive-compulsive personality disorder. Most persons with Obsessive Compulsive Disorder do not have premorbid compulsive symptoms, and such personality traits are neither necessary nor sufficient for the development of Obsessive Compulsive Disorder. Only about 15 to 35 percent of Obsessive Compulsive Disorder patients have had premorbid obsessional traits.
Psychodynamic Factors. Sigmund Freud originally conceptualized the condition we now call Obsessive Compulsive Disorder as obsessional neurosis. He assumed there was a defensive retreat involved in the face of anxiety-provoking Oedipal wishes. He postulated that the patient with an obsessive-compulsive neurosis regressed to the anal phase of psychosexual development. Freud’s theories are discussed below.

Psychodynamic insight may be of great help in understanding problems with treatment compliance, interpersonal difficulties, and personality problems accompanying the Axis I disorder. Many patients with Obsessive Compulsive Disorder may refuse to cooperate with effective treatments such as selective serotonin reuptake inhibitors SSRI’s) and behavior therapy. Even though the symptoms of Obsessive Compulsive Disorder may be biologically driven, psychodynamic meanings may be attached to them. Patients may become invested in maintaining the symptomatology because of secondary gains. For example, a male patient, whose mother stays home to take care of him, may unconsciously wish to hang on to his Obsessive Compulsive Disorder symptoms because they keep the attention of his mother.

Another contribution of psychodynamic understanding involves the interpersonal dimensions. Studies have shown that relatives will accommodate the patient through active participation in rituals or significant modifications of their daily routines. This form of family accommodation is correlated with stress in the family, rejecting attitudes toward the patient, and poor family functioning. Often the family members are involved in an effort to reduce the patient’s anxiety or to control the patient’s expressions of anger. This pattern of relatedness may become internalized and be recreated when the patient enters a treatment setting. By looking at recurring patterns of interpersonal relationships from a psychodynamic perspective, patients may learn how their illness affects others.

Finally, one other contribution of psychodynamic thinking is recognition of the precipitants that initiate or exacerbate symptoms. Often, interpersonal difficulties increase the patient’s anxiety and thus increase the patients’ symptomatology as well. Research suggests that Obsessive Compulsive Disorder may be precipitated by a number of environmental stressors, especially those involving pregnancy, childbirth, or
parental care of children. An understanding of the stressors may assist the clinician in an overall treatment plan that reduces the stressful events themselves or their meaning to the patient.

- **SIGMUND FREUD.** In classic psychoanalytic theory, Obsessive Compulsive Disorder was termed obsessive-compulsive neurosis and was considered a regression from the Oedipal phase to the anal psychosexual phase of development. When patients with Obsessive Compulsive Disorder feel threatened by anxiety about retaliation for unconscious impulses or by the loss of a significant object’s love, they retreat from the oedipal position and regress to an intensely ambivalent emotional stage associated with the anal phase. The ambivalence is connected to the unraveling of the smooth fusion between sexual and aggressive drives characteristic of the Oedipal phase. The coexistence of hatred and love toward the same person leaves patients paralyzed with doubt and indecision.

An example of how Freud viewed Obsessive Compulsive Disorder symptoms is described by Otto Fenichel in the following case.

A patient, who was not analyzed, complained in the first interview that he suffered from the compulsion to look backward constantly, from fear that he might have overlooked something important behind him. These ideas were predominant; he might overlook a coin lying on the ground; he might have injured an insect by stepping on it; or an insect might have fallen on its back and need his help. The patient was also afraid of touching anything, and whenever he had touched an object he had to convince himself that he had not destroyed it. He had no vocation because the severe compulsions disturbed all his working activity; however, he had one passion: housecleaning. He liked to visit his neighbors and clean their houses, just for fun. Another symptoms was described by the patient a his “clothes consciousness”; he was constantly preoccupied with the question whether or not his suit fitted. He, too, stated that sexuality did not play an important part in his life. He had sexual intercourse two or three times a year only, and exclusively with girls in whom he had been terribly afraid of touching her. There was no real reason whatsoever for such disgust, for the
mother had been a nice and popular person. From Fenichel O. The psychoanalytic Theory of Neurosis. New York: Norton; 1945:274. (With permission).

In this clinical picture, the need to be clean and not to touch is related to anal sexuality, and the disgust for the mother is a reaction against incestuous fears.

One of the striking features of patients with Obsessive Compulsive Disorder is the degree to which they are preoccupied with aggression or cleanliness, either overtly in the content of their symptoms or in the associations that lie behind them. Therefore, the psychogenesis of Obsessive Compulsive Disorder may lie in disturbances in normal growth and development related to the anal-sadistic phase of development.

- **Ambivalence:** - Ambivalence is the direct result of a change in the characteristics of the impulse life. It is an important feature of normal children during the anal-sadistic developmental phase; children feel both love and murderous hate toward the same object, sometimes simultaneously. Patients with Obsessive Compulsive Disorder often consciously experience both love and hate toward an object. This conflict of opposing emotions is evidence in a patient’s doing and undoing patterns of behavior and in paralyzing doubt in the face of choices.

- **Magical Thinking:** - In magical thinking, regression uncovers early modes of thought rather than impulses; that is, ego functions, as well as id function, are affected by regression. Inherent in magical thinking is omnipotence of thought. Persons believe that merely by thinking about an event in the external world they can cause the event to occur without intermediate physical actions. This feeling causes them to fear having an aggressive thought.

### 1.1.5 Clinical Features

Patients with Obsessive Compulsive Disorder often take their complaints to physicians other than psychiatrists. Most patients with Obsessive Compulsive Disorder have both obsessions and compulsion - upto 75 percent in some surveys. Some researchers and clinicians believe that the number may be much closer to 100 percent if patients are
carefully assessed for the presence of mental compulsions in addition to behavioral compulsions. For example, an obsession about hurting a child may be followed by a mental compulsion to repeat a specific prayer a specific number of times. Other researchers and clinicians, however, believe that some patients do have only obsessive thoughts without compulsions. Such patients are likely to have repetitive thoughts of a sexual or aggressive act that is reprehensible to them. For clarity, it is best to conceptualize obsessions as thoughts and compulsions as behavior.

Obsessions and compulsions have certain features in common: An idea or an impulse intrudes itself insistently and persistently into a person’s conscious awareness. A feeling of anxious dread accompanies the central manifestation and frequently leads the person to take counter measures against the initial idea or impulse. The obsession or the compulsion is ego-alien; that is, it is experienced as foreign to the person’s experience of himself or herself as a psychological being. No matter how vivid and compelling the obsession or compulsion, the person usually recognizes it as absurd and irrational. The person suffering from obsessions and compulsions usually feels a strong desire to resist them. Nevertheless, about half of all patients offer little resistance to compulsions, although about 80 percent of all patients believe that the compulsion is irrational. Sometimes patients overvalue obsessions and compulsions – for example, they may insist that compulsive cleanliness is morally correct, even though they have lost their jobs because for time spent cleaning.

1.1.6 DSM-V-TR Diagnostic Criteria for Obsessive-Compulsive Disorder

A. Presence of obsessions, compulsions, or both:

Obessions as defined by (1) and (2).

1) Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2) The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Or images are not simply excessive worries about real-life problems

Compulsions are defined by (1) and (2)

1) Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.

2) The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania (hair-pulling disorder); skin picking, as in excoriation (skin-picking) disorder; stereotypes, as in stereotypic movement disorder; ritualized eating behavior, as in
eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphillic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).

Specify if

**With good or fair insight:** The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.

**With poor insight:** The individual thinks obsessive-compulsive disorder beliefs are probably true.

**With absent insight/delusional beliefs:** The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Specify if:

**Tic-related:** The individual has a current or past history of a tic disorder.

<table>
<thead>
<tr>
<th>Specialist</th>
<th>Presenting Problem</th>
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<tbody>
<tr>
<td>Dermatologist</td>
<td>Chapped hands, eczematoid appearance&lt;br&gt;family member</td>
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<tr>
<td>Washing</td>
<td>Excessively, may mention counting or checking compulsions</td>
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<td>Oncologist, infectious</td>
<td>Insistent belief that person has acquired immune deficiency syndrome</td>
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<td>Disease internist</td>
<td>Obsessive-compulsive disorder associated with Tourette’s disorder,</td>
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<tr>
<td>Neurologist</td>
<td>Head injury, epilepsy, choreas, other basal ganglia lesions or disorders</td>
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<td>Neurosurgeon</td>
<td>Severe, intractable obsessive-compulsive disorder</td>
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<tr>
<td>Obstetrician</td>
<td>Postpartum Obsessive-Compulsive Disorder</td>
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<tr>
<td>Pediatrician</td>
<td>Parent’s concern about child’s behavior, usually excessive washing.</td>
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<td>Obsessive-compulsive disorder secondary to Sydenham’s chorea.</td>
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<td>Repeated consultations for “abnormal” features</td>
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<td>Dentist</td>
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1.2 OBSESSIVE-COMPULSIVE DISORDER SYMPTOM PATTERNS

The presentation of obsessions and compulsions is heterogeneous in adults and in children and adolescents. The symptoms of an individual patient may overlap and change with time, but Obsessive Compulsive Disorder has four major symptom patterns.

**Figure No. 1.4 The Relationship between obsessions and compulsions.**

1.2.1 Contamination: - The most common pattern is an obsession of contamination, followed by washing or accompanied by compulsive avoidance of the presumably contaminated object. The feared object is often hard to avoid (e.g., feces, urine, dust, or germs). Patients may literally rub the skin off their hands by excessive
hand washing or may be unable to leave their homes because of fear of germs. Although anxiety is the most common emotional response to the feared object, obsessive shame and disgust are also common. Patients with contamination obsessions usually believe that the contamination is spread from object to object or person to person by the slightest contact.

**Contamination Fears**

One of the most prevalent obsessions is a fear of contamination, which accounts for approximately a quarter of all obsessive themes in the US and is the most common Obsessive Compulsive Disorder concern worldwide. Typically the contamination worry is based on a fear of some sort of disease or illness (usually death, but sometimes other concerns such as a fear of blindness or religious concerns are a factor). For example, one might fear developing cancer or disease and so worry about toxic materials to an extreme, such as x-rays, asbestos, or many other numerous carcinogens occurring either naturally or in everyday products.

**Figure No. 1.5 Compulsion of Hand washing due to contamination fear.**

Clearly something such as asbestos is dangerous in real life (it is no longer used commonly as it is illegal, but a lot of older homes and building still have things made out of asbestos or other dangers such as lead paint), but a person with contaminationObsessive Compulsive Disorder would take the fear to the extreme. When walking past a home with asbestos siding, the Obsessive Compulsive Disorder sufferer might start to
imagine that rain water had washed the asbestos particles onto the sidewalk, and now that it was dry that they might actually be stepping on asbestos particles which were then billowing into the air and attaching onto their clothes. Or even that the asbestos siding had deteriorated (even if it was clearly well encapsulated) so much that it was in the air and attaching to their clothes and indeed infecting everything in proximity. Whereas a regular person would realize that while harmful, the asbestos would really only be dangerous if they were to break it apart and start sniffing in the dust, and that while there are a lot of dangers everyday life, that if everything was so dangerous we would all be sick and dead already (in this case via cancer). Depending on where the contamination obsession resides in an Obsessive Compulsive Disorder sufferers' hierarchy or the severity of the Obsessive Compulsive Disorder, determines the extremes to which these obsessions can manifest. Often times a person with contamination fears will get to the point where virtually everything except a small safe area is contaminated, since the contamination has spread. Since the obsession is in regards to disease or illness one with Obsessive Compulsive Disorder often feels a sense of responsibility to protect others from the contaminants. This is often where tension is created or stress is caused by those close to an Obsessive Compulsive Disorder sufferer as they will insist on friends and loved ones avoiding contaminants for fear of them being contaminated or spreading the germs to their safe zones.

While fear of illness or disease is the root of most contamination obsessions, it is not always the case. A good example is people that are bothered by sticky or greasy substances. In cases such as these often the reason for being bothered by the substance can't even be articulated except for a discomfort. Those with Obsessive Compulsive Disorder often suffer from a heightened sense of symmetry so perhaps getting something sticky on one's hand leads to discomfort.

**Common Obsessions**

**A list of some common concerns:**

**Dirt and germs.** This includes things like HIV, swine flu, Lyme disease, etc. The person might be worried about getting a sickness or disease by touching a public door handle, using a public restroom, or handling money. A person with Obsessive
Compulsive Disorder would ruminate on all the people that may have touched the money and the various contaminants stuck to it received from its travels.

**Household items.** This includes things like cleaning supplies, bleach, pesticides, hair dye, etc. For many people with Obsessive Compulsive Disorder, cleansers are the person's best friend, but to others the cleaning supplies are a potential source of danger. Someone with cancer fears might examine every product for toxins or carcinogens. Many products do have trace amounts of carcinogens (such as hair dye or strong household cleaners), so for someone with a cancer fear, this can be overwhelming. Looking at the small print on numerous items at the hardware store can show, "this product is known to cause cancer in mice in the state of California" or other such descriptions. We eat processed foods, things lathered in pesticides, etc. but most people can deal with the small risks. Of course there are people that avoid things such as pesticides or common items with toxins by eating organic since they want to avoid long term exposure to these chemicals, but if they were to handle an orange that was sprayed with pesticides, they would not feel the need to have a shower, wash their clothes and decontaminate everything exposed to the orange. This, of course, is the difference. A regular person realizes one orange covered with pesticides will not cause instant cancer, and while an Obsessive Compulsive Disordered would realize this as well, their obsession would cause such distress that the "what if?" would be impossible to overcome

**Environmental contaminants.** This includes things like radiation, asbestos, pesticides, toxic waste, radon, mold, lead paint, etc. Most people just accept that we live in a dangerous world that carries risks. Someone with contamination obsessions of sickness or death cannot operate this way, even if they logically can. The nagging and doubt gnaws at the person.

**Bodily waste or secretions.** This includes things like feces, blood, semen, saliva, etc. An Obsessive Compulsive Disorder sufferer might worry about getting E. coli from feces, getting HIV/AIDS from blood or accidentally impregnating someone with their semen. If AIDS is the obsession of the week, a spot of red in public may lead an Obsessive Compulsive Disorder mind to imagine a person with AIDS was cut and left infected blood where the red spot was. Even if it's obvious it is something else, i.e.
dried tomato sauce, the Obsessive Compulsive Disorder mind would be asking what if until the Obsessive Compulsive Disorder sufferer says okay, I'll clean just to be safe (momentarily quieting the anxiety).

**Sticky or greasy substances.** This includes things like stickers, glue, cooking oil, etc.

**Animals or insects.** For many with contamination Obsessive Compulsive Disorder animals just feel dirty. A big shaggy dog coming in from outside and rubbing up to an Obsessive Compulsive Disorder with its big messy coat or licking with is tongue is an example of something that might just feel dirty to some. Someone with Obsessive Compulsive Disorder might simply feel disgusted with flies in general and the fact that the land on and feed from disgusting surfaces. If the person were simply afraid of the animal or insect, that would be considered a specific phobia, not Obsessive Compulsive Disorder.

Going back to asbestos, when walking by a home with asbestos siding, an Obsessive Compulsive Disorder sufferer with such a fear might see a fly landing on the siding and then worry about the fly landing on them and transferring the contaminants. Someone with more severe Obsessive Compulsive Disorder might worry about any fly in the area landing on him or her because it may have touched the siding at some point. An even more extreme example would be someone in the safety of their own home nowhere near any asbestos being touched by a fly and concocting a scenario whereby the fly had been on asbestos siding in some elaborate scenario.
“The Effect of Cognitive Behavior Therapy In Obsessive Compulsive Disorder.”

Table No. 1.2: Obsessive- Compulsive Symptoms in Adults

<table>
<thead>
<tr>
<th>Variable</th>
<th>%</th>
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<tr>
<td>Obsessions (N =200)</td>
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<tr>
<td>Contamination</td>
<td>45</td>
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<tr>
<td>Pathological Doubt</td>
<td>42</td>
</tr>
<tr>
<td>Somatic</td>
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<tr>
<td>Need for Symmetry</td>
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<td>Compulsions (N = 200)</td>
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<td>Washing</td>
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</tr>
<tr>
<td>Present</td>
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</tr>
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</table>
1.2.2 Pathological Doubt: - The second most common pattern is an obsession of doubt, followed by a compulsion of checking. The obsession often implies some danger of violence (e.g., forgetting to turn off the stove or not locking a door). The checking may involve multiple trips back into the house to check the stove, for example. The patients have an obsessional self-doubt and always feel guilty about having forgotten or committed something.

Causing Harm by Accident

Many fear that harm will come to love ones or others because of not being careful enough.

People with Obsessive Compulsive Disorder often feel very responsible for their actions, and sometimes even for events that are outside of their control. They may doubt if they performed an important task correctly, or even if they performed it at all. As a result, their primary compulsion tends to be repetitive checking. It's no surprise that Obsessive Compulsive Disorder is often called the disease of doubt.

People who repeatedly doubt are often thought of as having a fear of causing harm or fear of being responsible for harm. Individuals whose primary obsessional symptoms fall within this category typically experience intrusive images, impulses, and fears related to the possibility of harming them or someone else by means of carelessness or negligence. For example, some of the more common harming fears include the fear of hitting a pedestrian while driving or the fear of forgetting to turn off the stove before going to bed, thereby leading to the death of a loved one in a subsequent fire. Accompanying the fear of harm is often an excessive feeling of doubt, dread, or uncertainty. Such people may have no concerns when others perform these actions as it relieves the Obsessive Compulsive Disorder sufferer of the burden of responsibility of having caused the harm, should harm result.

People with obsessional doubt also tend to report being doubtful of their own memory of their actions, and there has been some research into the idea that people who repeatedly check may have some actual memory problems. Studies have generally found that Obsessive Compulsive Disorder patients who check are less confident in their memories and have poorer performance on certain types of memory tasks. It is not
completely clear if this is an actual brain problem or simply interference from high levels of anxiety.

**Common Doubting Fears**

**Accidentally hitting a pedestrian while driving.**

One common doubting fear is accidentally hitting a pedestrian while driving. The person with Obsessive Compulsive Disorder might see someone on the side of the road and drive by them. After turning the next street, they may start to worry that the little bump they felt in the road was actually their car hitting the pedestrian. The person knows deep down that they did not hit the pedestrian, but they will be plagued by "what if..." Usually the person with Obsessive Compulsive Disorder knows their obsessions are just that, obsessions. An obsession such as this especially that is a little more farfetched. But, the obsession will contrive some elaborate possibility, leaving that shred of doubt. The Obsessive Compulsive Disorder sufferer is likely to ruminate until the doubt gets so intolerable that they must turn around and drive back to where they last saw the pedestrian.

When going back to the spot, the Obsessive Compulsive Disorder sufferer may then worry that they misremembered the spot or that the body flew far from the spot after being hit, and for example, landed at some hidden angle in a ditch. Numerous thoughts could pop up such as a concern the person is laying there suffering. Depending on the severity of the Obsessive Compulsive Disorder, the person could continue to check the area over and over or continue to think about every detail they remember to convince them that they did not hit the pedestrian. With Obsessive Compulsive Disorder obsessions such as this, the person might even fear seeing a pedestrian, knowing they will go through this stressful thought process after they pass them. Some people with Obsessive Compulsive Disorder give up driving due to these concerns.

**Leaving on a stove, oven, curling iron, or hair dryer...**

A more common and potentially feasible fear is leaving on hot items that can cause a fire. This includes things like the stove, oven, curling iron, or hair drye. With Obsessive Compulsive Disorder the actual obsession is ultimately irrelevant, as no matter how big
or small it can be equally torturous. Obsessions such as forgetting to turn off the stove could almost be worse than the fear of hitting the pedestrian. Deep down the Obsessive Compulsive Disorder sufferer probably knows they didn't hit a pedestrian, but even a person who doesn't suffer from Obsessive Compulsive Disorder could have such a concern. Someone might have left the home 5 minutes ago and have the fleeting worry that they forgot to unplug the hair dryer. Anyone might be prompted to go home and check the stove, but an Obsessive Compulsive Disorder sufferer will go check, and then leave a second time only to doubt they correctly checked the switch and go back a second or third time (or more depending on the severity). If this were a main obsession, the Obsessive Compulsive Disorder sufferer would have this fear every time they leave the house, whereas this would happen to a person without Obsessive Compulsive Disorder very rarely.

A common compulsion with this is where the person with Obsessive Compulsive Disorder stares at the switches on the stove, then leaves the room, only to come back in and check again before even leaving the house. Sometimes people with Obsessive Compulsive Disorder feel a certain comfort or symmetry checking things a certain amount of time. So, the Obsessive Compulsive Disorder sufferer may look at each switch four times, then leave the room, and come back and do this four times (checking four times each time). Someone with Obsessive Compulsive Disorder may not have a checking number that feels right, but they are at least likely to have a specific system that convinces them that they have checked properly and thoroughly. Much in the way a person with contamination fear overdoes it when they wash their hands, a person checking the light switch is probably doing so in an extreme way. People with Obsessive Compulsive Disorder have even been known to take pictures of certain items to reference later to be sure they are turned off.

**Leaving a door or window unlocked resulting in a robbery.**

Another common doubting fear is leaving a door or window unlocked, resulting in a robbery. This is very similar in nature to the fears of causing a fire. The fear of hitting a pedestrian or burning down your house certainly sounds horrifying, but if a fear of leaving the door unlocked is the obsession of the week, then the doubt would bother every bit as much. It is not the severity of the level of disaster that causes the distress,
but rather the severity of the Obsessive Compulsive Disorder. For these doubting fears it is very likely that a person who worry's he forgot to lock their door is also probably worried they forgot to turn off the stove as well. Worries about checking locks may be reasonable if one lives in a high crime area, but people with Obsessive Compulsive Disorder will worry even when there is no danger present.

**Aggressive Obsessions**

People with Obsessive Compulsive Disorder often worry that they will cause harm by impulsively hurting someone just because they can. People with these thoughts typically have no history of violence, nor do they act on their urges or impulses. However, people with Obsessive Compulsive Disorder often appraise their thoughts as dangerous and overly important, so when a random thought involving harm enters the person's mind, the Obsessive Compulsive Disorder sufferer begins to worry. They often believe that having such a thought are as bad as performing the action, thus they devoting a large amount of their mental effort to attempts to suppress the thoughts. Conversely, this only serves to increase anxiety and perpetuate symptoms. Below are some common fears.

**Harming others impulsively**

One of the most upsetting types of aggressive obsessions concern worries that a person may cause harm to others impulsively. For example, the person may fear that they will punch a friend, when they are not angry, but just because they can. They may be concerned that they might push an elderly person into subway tracks or push a child into oncoming traffic. Another common fear is that the person might stab a loved one while using a kitchen knife. The focal point of these worries is usually loved ones, but can be strangers or pets. Sometimes the person is not worried about harming others, but worries about harming him or herself, which is not to be confused with suicidal ideation as people with these types of fears will do anything to avoid causing the harm they worry about.

A person without Obsessive Compulsive Disorder might be standing behind a loved one at say the Grand Canyon, and randomly get a thought of pushing the loved one over the edge. They would never do it or have a desire to do it, so they might just
chuckle inwardly and think what a silly thought. Or they might even shiver for a second with discomfort. But, most people would realize this was just a random thought that jumped into their head and had no significance. We all have weird thoughts from time to time. A person with harming obsessions would probably latch onto this thought and do compulsion after compulsion in response to make the worry go away. Also, if a person is afraid of thinking something, then they are more likely to think it. So, if you're always worrying about accidentally harming someone, or harming someone because you're worried you will lose control and do so, you see a person standing at the edge of a cliff, your mind is probably more likely to have a thought of pushing them in. The Obsessive Compulsive Disorder might even just worry that it's going to have the thought and not actually have it. The person would be doing mental compulsions over and over reassuring themselves that they didn't have the thought, or weren't going to, or if they did, they didn't mean and here's why, etc.

**Doing something shocking or embarrassing**

Also falling into this category of obsessions is a fear doing shocking or embarrassing things. An example of this might be a fear of swearing by accident, blurring out obscenities or insulting someone on purpose. For instance, the person might be sitting in church, and worry they are going to scream out a swear word. The person would not do this, nor do they want to, but the Obsessive Compulsive Disorder tells them they might or maybe they did and did not realize. This is not too be confused with something like Tourette syndrome.

This may manifest itself in a fear of doing something embarrassing, like doing a task wrong to let everyone down, forgetting the words in a speech, writing something incorrectly in an email. Many people are afraid of public speaking, but for a person with Obsessive Compulsive Disorder the reason for that might be different if they have this form of obsessions. They may be trembling with anxiety, but it could be because they are terrified they will forget their words, blurt out a swear word or that they killed a person (not true), or maybe they even worry that there will be a hole in their clothes and a private area might be showing. A normal person may worry that their speech will fall flat or that they might forget something, but this anxiety manifests itself differently. Unless the person has social phobia (which actually is often co morbid with Obsessive
Compulsive Disorder), in which case the anxiety may be even more debilitating, an Obsessive Compulsive Disordered with these fears might obsess for weeks in advance of a big event like this.

The person with this form of Obsessive Compulsive Disorder might also have a fear of doing something non violent but illegal. For example, they might worry that they will accidentally steal something, and come home with a pocket full of stolen goods. They might even worry that they will look wrong at the security guard in a department store, who will then suspect of them of being a thief.

1.2.3 Intrusive Thoughts: - In the third most common pattern, there are intrusive obsessional thoughts without a compulsion. Such obsessions are usually repetitious thoughts of a sexual or aggressive act that is reprehensible to the patient. Patients obsessed with thoughts of aggressive or sexual acts may report themselves to police or confess to a priest.

Sexually Intrusive Thoughts

Sexually intrusive thoughts are extremely common, and among the general population, over ninety percent of individuals report having experienced these type of thoughts during their lifetime. Studies have found that as many as a quarter of Obsessive Compulsive Disorder patients have had a history of sexual obsessions. These numbers may be an underestimate of the actual number of people suffering from unwanted sexual obsessions because the stigma associated with sexual thoughts may cause individuals to avoid reporting their obsessions. Sexual obsessions and sexually intrusive thoughts are equally divided among males and females. These thoughts typically start in early adolescence and may progressively worsen, or have a waxing and waning course.

When conceptualizing sexual obsessions, it is important to recognize that people with sexual obsessions find their thoughts immoral and do not wish to act them out. They are different from fantasies, as the obsessions are unpleasant and provoke guilt, rather than being enjoyable. As a result, the thoughts cause distress, which may be connected to unwanted emotions, such as lust, disgust, anger, and frequently guilt. This distress is
directly related to the frequency of the sexual obsessions, and may lead to depression, difficulties concentrating, and anxiety.

**Treatment for Sexually-Themed Obsessive Compulsive Disorder**

Even licensed psychologists frequently misdiagnose sexual obsessions in Obsessive Compulsive Disorder. Thus it is vitally important that people with sexual obsessions in Obsessive Compulsive Disorder be treated by an experienced and effective Obsessive Compulsive Disorder therapist.

**Sexual Obsessive Compulsive Disorder Symptoms**

Obsessions in Obsessive Compulsive Disorder can take many different forms, including sexual obsessions. Such sexual obsessions may involve homosexual activities or fears about sexual orientation.

Obsessions about sexual orientation differ from an individual who is actually gay because the person with Obsessive Compulsive Disorder does not generally feel attraction or sexual arousal to members of the same sex. The individual with sexual orientation obsessions fears becoming gay or discovering that he or she was unknowingly gay all along. There is a shortage of research examining sexual orientation obsessions in Obsessive Compulsive Disorder (SO-Obsessive Compulsive Disorder), sometimes called HObsessive Compulsive Disorder for "homosexual Obsessive Compulsive Disorder."

**Sexual Orientation Obsessions (SO-Obsessive Compulsive Disorder)**

The obsessions in SO-Obsessive Compulsive Disorder take the form of worry about becoming or being gay, engaging in same-sex sexual behavior, and being ridiculed by others for being gay. This type of Obsessive Compulsive Disorder is often characterized by excessive doubt. The individual may first experience sexual orientation fears when noticing that a member of the same sex is attractive. The individual then questions why they had the thought and mentally panics, leading to more questioning. These fears are more than just fleeting thoughts; they become powerful obsessions that keep coming back.

In an effort to make the thoughts stop, the individual performs compulsions, which may present as checking for indications of physical arousal when around attractive members.
of the same sex. Symptoms also include avoidance, such as not watching television shows in which there is an LGBTQ character or avoiding spending time with same sex friends. Conversely, the individual may watch pornography with homosexual characters to determine if it arouses them, and then compare their reactions with heterosexual pornography. Another common compulsion to combat the obsessions is to increase sexual intercourse with a partner in order to reassure the individual that s/he still enjoys sexual activity with someone of the opposite sex. People with sexual orientation obsessions are driven by the fear of losing access to people of the opposite sex and acquiring an attraction to people of the same sex.

It is reported that homosexual obsessions have lifetime rates of about ten percent among treatment-seeking people with Obsessive Compulsive Disorder. In addition, it appears that more males experience sexual orientation obsessions than females. The lack of a specific diagnostic tool to identify people with this subtype of Obsessive Compulsive Disorder can cause people to be undiagnosed or misdiagnosed by clinicians that are not experienced in treating people with Obsessive Compulsive Disorder. Such a therapist may mistakenly believe that the individual is undergoing a sexual identity crisis due to "being in the closet," and this sort of discussion only increases the fear in the individual. Being unable to obtain a proper diagnosis or proper treatment may lead to feelings of hopelessness, despair, and even suicidal ideation. This makes sexual orientation obsessions a particularly worrisome type of Obsessive Compulsive Disorder. Thus it is vitally important that people with sexual obsessions in Obsessive Compulsive Disorder be treated by an experienced and effective Obsessive Compulsive Disorder therapist.

**Religious Obsessive Compulsive Disorder Subtype**

Religious thoughts can become intrusive and distressing in individuals with Obsessive Compulsive Disorder. These thoughts can involve intrusive religious blasphemous thoughts, compulsive prayer, hyper morality, unwarranted concern about committing a sin, and cleaning/washing rituals (Himle, Chatters, Taylor & Nguyen, 2001). These thoughts sometimes become problematic, and are referred to as "scrupulosity." Scrupulosity describes the relationship between religiosity and the symptoms of
Obsessive Compulsive Disorder, and individuals with these obsessions often focus on certain details of their religion while ignoring others.

One large study found that scrupulous obsessions in Obsessive Compulsive Disorder were ranked as the fifth most common obsession, with 6% of participants endorsing it as their primary obsession. Additionally, it has been estimated that religious obsessions occur in 25% of individuals with Obsessive Compulsive Disorder (Antony, Dowie, & Swinson, 1998). One study showed that Obsessive Compulsive Disorder symptoms presentation could be influenced by one's religion and culture (Sica, Novara, Sanavio, Dorz & Coradeschi, 2002). Abramowitz, Deacon, Woods, & Tolin (2004) highlighted this point by finding that Protestant individuals with high levels of religiosity had the highest severity of Obsessive Compulsive Disorder symptoms.

Individuals with scrupulous obsessions may have anxiety related to their religion, sinning, and guilt, which can cause religious practices and rituals to become compulsive (Deacon & Nelson, 2008; Gonsalvez et al., 2009). Also, these individuals are often more religious and more likely to seek out religious counseling and less likely to receive medical treatment (Siev, Baer, & Minichiello, 2011). They also found that a negative concept of God was associated with higher symptom severity, and that one in five did not subscribe to a particular religious affiliation. In line with the negative God concept, those that believe that their God is punitive will likely engage in more severe compulsions to make up for minor sins, even though the clergy is aware that their sins are minor and do not need compulsive actions (Gonsalvez et al., 2010). In addition, 20% stated that their Obsessive Compulsive Disorder symptoms help them in observing their religion.

While it may be easy to assume that people with these types of worries are from very religious or strict traditions, these worries can strike the very orthodox, non-religious people, or even atheists. Scrupulosity should not be confused with being obsessed with religion or being very devout. People with this type of Obsessive Compulsive Disorder do not feel more spiritual or fulfilled by performance of Obsessive Compulsive Disorder-related rituals, which may include repeating prayers, seeking reassurance, or mental rituals.
Treatment for Religious-Themed Obsessive Compulsive Disorder

Elliott and Radomsky (2008) suggest that through collaboration with clergy counselors and members of the religious community, psychologists could provide adequate support for individuals suffering from scrupulous obsessions. Religious leaders can determine within their doctrine, which rituals are extreme and which are appropriate, and they may be able to offer guidance and treatment. Additionally, highly religious individuals often consult their religious leaders rather than clinicians for help (Miller et al., 2008), so providing Obsessive Compulsive Disorder education and specialized treatment trainings in religious settings could be beneficial to bringing therapies that have been shown to be effective to more people suffering from these obsessions.

1.2.4 Symmetry: - The fourth most common pattern is the need for symmetry or precision, which can lead to a compulsion of slowness. Patients can literally take hours to eat a meal or shave their faces.

Obsessions with Symmetry

Some people with Obsessive Compulsive Disorder have obsessions surrounding the way objects are arranged. These people may feel very uncomfortable when confronted with situations where objects are misaligned or in disarray. On a related note, some people may be made uncomfortable when something does not appear perfect. They may not be able to tolerate having written something where the letters may be shaped imperfectly. The corresponding compulsions would be ordering and arranging or compulsive corrections. When movies attempt to portray Obsessive Compulsive Disorder, they often throw in seemingly random behaviors. But it is important for outsiders to remember that even if the Obsessive Compulsive Disordered is doing something that appears random, or just crazy, that is never the case. There is always some base reason, even if it seems illogical or magical.

It's Not Just Personality

People with symmetry concerns may be more likely to have other anxiety disorders or obsessive-compulsive personality disorder. People with this type of Obsessive Compulsive Disorder typically have an earlier age of onset and are more likely to have close family members with Obsessive Compulsive Disorder. It is important to note that
while OCPD and Obsessive Compulsive Disorder appear to have some superficial similarities in concerns, the key difference is that those with OCPD are not stressed or bothered by their thoughts, and cannot even really be called obsessions. Whereas a person with symmetry concerns is caused great distress by their obsessions. This is called for Obsessive Compulsive Disorder ego-dystonic (Obsessive Compulsive Disorder obsessions are not considered reasonable, and are foreign and unwelcome) versus ego-syntonic (the thoughts are seen as reasonable and part of ones self). So, to an outsider they may appear similar, or even affect a family member or friend in the same way, but Obsessive Compulsive Disorder always causes the sufferer more distress than even the most traumatized family member.

**Dysfunctional Protecting**

People with most forms of Obsessive Compulsive Disorder are usually doing compulsions in response to their obsessions to protect themselves or those around them. It feels ridiculous to arrange something just perfectly so a family member doesn't get cancer, but the Obsessive Compulsive Disordered is usually so caring and worried that they don't want to be the cause by just being lazy. It could even go through their mind that it is some magical karma for not caring enough.

**Needs to Feel Right**

In other cases, the need for symmetry may just "feel right" and not be accompanied by magical thinking (e.g. just makes the person uncomfortable). For instance, a person may scratch one side of their face, but then the other side will feel weird until scratched the same way for the same amount of time. Some non Obsessive Compulsive Disorder people may have a preference for symmetry, but the Obsessive Compulsive Disorder will scream for the symmetry in this case, and cause great distraction until satisfied. It is hard for someone without Obsessive Compulsive Disorder to conceptualize, but if one side of the face has been scratched a good way to understand how distracting it would be to the Obsessive Compulsive Disordered is to imagine one sitting in a rock on one side of their body but not the other. This is how much discomfort the nagging need for symmetry can cause.
Ordering & Arranging

People with Obsessive Compulsive Disorder who tend to be primarily preoccupied with order and exactness tend to engage in compulsive behaviors that include repetitive arranging, organizing or lining up of objects until certain conditions are met or the end result feels "just right." These individuals are commonly referred to as perfectionists due to their need to arrange and order with such exactness and precision.

Arranging in the "Correct" Way

When objects are not set up in the "correct" way, these individuals often report a feeling of discomfort and incompleteness. For example, a patient may get very anxious if the books and papers on his desk are not symmetrically aligned or set a certain distance from one another.

Patients may feel they need to arrange objects a certain number of times before they are satisfied. They may also incorporate special patterns into their routine while ordering. Some patients may also engage in mental ordering and counting. Since belongings of these individuals must be set in specific places and positions, sufferers may be slow to get through everyday tasks, such as setting the table or tidying the house. They may also become distressed or enraged if others move their things.

Other Related Compulsions

People with this sort of Obsessive Compulsive Disorder may write letters over and over again until they look right or may meticulously line up the shoes in their closet so that they form one continuous straight row. Individuals with this type of Obsessive Compulsive Disorder may also engage in counting, tapping, and touching behaviors.

1.2.5 Other Symptom Patterns: - Religious obsessions and compulsive hoarding are common in patients with Obsessive Compulsive Disorder. Trichotillomania (compulsive hair pulling) and nail biting may be compulsions related to Obsessive Compulsive Disorder.
Miscellaneous Obsessions
- Need to know or remember (e.g. if hears part of some information, the person needs to hear the rest)
- Fear of saying certain things
- Fear of not saying just the right thing (e.g. need to be perfectly understood)
- Fear of losing things
- Lucky and/or unlucky numbers (i.e. that 4 is good and 13 is bad)
- Colors with special significance (i.e. red is bad because of the devil, etc.)
- Superstitious fears (e.g. can't step on a crack)
- Fear that one already has terrible illness or disease

Unusual Obsessions
- Excessive concern with body part of aspect of appearance (not weight related)
- Bothered by certain sounds or noises
- Intrusive (non-violent) images (i.e. cartoons, faces, clouds)
- Intrusive nonsense sounds, words, or music
- Losing one's personality or positive qualities

Other Compulsions
- Superstitious behaviors
- Self-damaging or self-mutilating behaviors: For example, biting nails to make them all even, or picking skin to address an imperfection.

Unusual Compulsions
- Urges to touch, tap, or rub
- Rituals involving blinking or staring
- Ritualized eating behaviors (e.g. eating foods in certain order, etc.)

Common Compulsions
Because the symptoms of obsessive-compulsive disorder are so specific to each individual, there are many symptoms that do not fit neatly within any particular category. Below are some typical compulsive behaviors that have not been the focus of
much research, but are nonetheless quite common. Compulsions are any behavior performed by someone with Obsessive Compulsive Disorder to quell the obsessions. They do not work in the long run as the relief is only temporary, and the person with Obsessive Compulsive Disorder does not learn that the compulsions are unnecessary.

**Excessive list-making:** People with Obsessive Compulsive Disorder often fear they will forget something important, so they may make excessive lists to remind them to do daily routine activities (i.e. brush teeth, make breakfast, etc.) However, research has shown that people with Obsessive Compulsive Disorder do not have memory problems, so the lists are actually unnecessary. List making would be considered a compulsion because the list reassures the person with Obsessive Compulsive Disorder and helps them to feel temporarily better, thus they never learn that they do not need the list to remember things. People with Obsessive Compulsive Disorder may also make lists to remember things that may be contaminated to later wash or avoid, which also contributes to the Obsessive Compulsive Disorder process. List making can be in writing or verbalized aloud.

**Urges to tell or confess:** People with Obsessive Compulsive Disorder may constantly wonder if they have done something wrong or made a mistake. One way they often try to cope with this fear is by telling every detail of their actions to another person. This behavior can be particularly troublesome in relationships, as for example, a husband may have an urge to tell his wife every time he notices an attractive woman, to assure her she does not think he is looking at her in an improper manner. Likewise, Catholics may feel compelled to confess every small sin to the priest to be sure that they have not accidentally omitted a cardinal sin to prevent damnation. People with Obsessive Compulsive Disorder may even stress their therapists as they may feel the need to disclose every detail of their past mental health history to be sure that the therapist will have all the information needed to render a proper diagnosis and treatment plan. As a result people often get tired and frustrated listening to the person with Obsessive Compulsive Disorder confess or explain things to an extreme degree. The need to tell or confess is often coupled by the need to obtain reassurance (see below).
**Excessive reassurance seeking:** People with Obsessive Compulsive Disorder often seek reassurance from others as a way of reducing anxiety from obsessions. Research has shown that people plagued by obsessions about sex, religion, morality, and bodily concerns tend to be the most likely to use reassurance to cope with their distress. Requests for reassurance can come in the form of demands or can be elicited more subtly. People with concerns about illness may visit a doctor repeatedly to be reassured that they have not contracted an illness. People, who worry about having said the wrong thing, may seek reassurance from others to ensure that have caused offense. People who use reassurance to cope can be very skilled at eliciting reassuring feedback from others, and neither party may even be aware that the obsessive-compulsive process is occurring. Therapists often provide reassurance to clients as part of the treatment process, but people with Obsessive Compulsive Disorder should not be reassured as this only perpetuates the Obsessive Compulsive Disorder cycle.

**Table No. 1.3**

**Reported Obsessions and Compulsions for 70 Consecutive Child and Adolescent Patients**

<table>
<thead>
<tr>
<th>Major Presenting Symptom</th>
<th>No. (%) Reporting Symptom at Initial Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obsession</td>
<td></td>
</tr>
<tr>
<td>Concern or disgust with bodily wastes or secretions</td>
<td>30(43)</td>
</tr>
<tr>
<td>(Urine, stool, saliva), dirt, germs, environmental toxins.</td>
<td></td>
</tr>
<tr>
<td>Fear something terrible may happen</td>
<td>18 (24)</td>
</tr>
<tr>
<td>(Fire, death or illness of loved one, self or others)</td>
<td></td>
</tr>
<tr>
<td>Concern or need for symmetry, order, or exactness</td>
<td>12 (17)</td>
</tr>
<tr>
<td>Scrupulosity (excessive praying or religious concerns)</td>
<td>9(13)</td>
</tr>
</tbody>
</table>
Out of keeping with patient’s back-ground)

<table>
<thead>
<tr>
<th>Lucky and unlucky numbers</th>
<th>6 (8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forbidden or perverse sexual thoughts, images, or impulses</td>
<td>3 (4)</td>
</tr>
<tr>
<td>Intrusive nonsense sounds, words or music</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>

**Compulsion**

<table>
<thead>
<tr>
<th>Excessive or ritualized hand washing, showering, Bathing, tooth brushing or grooming</th>
<th>60 (85)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeating rituals (e.g., going in and out of door up and down from chair)</td>
<td>36 (51)</td>
</tr>
<tr>
<td>Checking doors, locks, stove, appliances, car brakes</td>
<td>32 (46)</td>
</tr>
<tr>
<td>Cleaning and other rituals to remove contact with contaminants.</td>
<td>16 (23)</td>
</tr>
<tr>
<td>Touching</td>
<td>14 (20)</td>
</tr>
<tr>
<td>Ordering and arranging</td>
<td>12 (17)</td>
</tr>
<tr>
<td>Measures to prevent harm to self or others (E.g., hanging clothes a certain way)</td>
<td>11 (16)</td>
</tr>
<tr>
<td>Counting</td>
<td>13 (18)</td>
</tr>
<tr>
<td>Hoarding and collecting</td>
<td>8 (11)</td>
</tr>
<tr>
<td>Miscellaneous rituals (e.g., licking, spitting, special dress pattern)</td>
<td>18 (26)</td>
</tr>
</tbody>
</table>

### 1.3 MENTAL STATUS EXAMINATION

On mental status examinations, patients with Obsessive Compulsive Disorder may show symptoms of depressive disorders. Such symptoms are present in about 50 percent of all patients. Some Obsessive Compulsive Disorder patients have character traits suggesting obsessive-compulsive personality disorder (e.g., excessive need for preciseness and neatness), but most do not. Patients with Obsessive Compulsive Disorder, especially men, have a higher than average celibacy rate. Married patients have a greater than usual amount of marital discord.
Ms. B presented for psychiatric admission after being transferred from a medical floor where she had been treated for malnutrition. Ms. B. had been found unconscious in her apartment by a neighbor. When brought to the emergency room by ambulance, she was found to be hypotensive and hypokalemic. At psychiatric admission, Ms. B. described a long history of recurrent obsessions about cleanliness, particularly related to food items. She reported that it was difficult for her to eat any food unless she had washed it three to four times, since she often thought that a food item was dirty. She reported that washing her food decreased the anxiety she felt about the dirtiness of food. While Ms. B. reported that she occasionally tried to eat food that she did not wash (e.g., in a restaurant), she became so worried about contracting an illness from eating such food that she could no longer dine in restaurants. Ms. B. reported that her obsessions about the cleanliness of food had become so extreme over the past 3 months that she could eat very few foods, even if she washed them excessively. She recognized the irrational nature of these obsessive concerns but either could not bring her to eat or became extremely nervous and nauseous after eating.

1.4 DIFFERENTIAL DIAGNOSIS

- **Medical Conditions**

The major neurological disorders to consider in the differential diagnosis are Tourette’s disorder, other tic disorders, temporal lobe epilepsy, and, occasionally, trauma and postencephalitic complications.

- **Tourette’s Disorder**

The characteristic symptoms of Tourette’s disorder are motor and vocal tics that occur frequently and virtually every day. Tourette’s disorder and Obsessive Compulsive Disorder have a similar age of onset and similar symptoms. About 90 percent of persons with Tourette’s disorder have compulsive symptoms, and as many as two thirds meet the diagnostic criteria for Obsessive Compulsive Disorder.
Other Psychiatric Conditions

The major psychiatric considerations in the differential diagnosis of Obsessive Compulsive Disorder are schizophrenia, obsessive-compulsive personality disorder, phobias, and depressive disorders. Obsessive Compulsive Disorder can usually be distinguished from schizophrenia by the absence of other schizophrenic symptoms, by the less bizarre nature of the symptoms, and by the patient’s insight into the disorder. Obsessive-compulsive personality disorder does not have the degree of functional impairment associated with Obsessive Compulsive Disorder. Phobias are distinguished by the absence of a relation between obsessive thoughts and compulsions, usually a compulsion of avoidance. Major depressive disorder can sometimes be associated with obsessive ideas, but patients with only Obsessive Compulsive Disorder fail to meet the diagnostic criteria for major depressive disorder.

Other psychiatric conditions that may be closely related to Obsessive Compulsive Disorder are hypochondriasis, body dysmorphic disorder, and possibly other impulse-control disorders, such as kleptomania and pathological gambling. In all these disorders, patients have either a repetitious thought (e.g., concern about the body) or a repetitious behavior (e.g., stealing). Compulsive sexual behavior may bear a relation to Obsessive Compulsive Disorder.

1.5 COURSE AND PROGNOSIS

More than half of patients with Obsessive Compulsive Disorder have a sudden onset of symptoms. The onset of symptoms for about 50 to 70 percent of patients occurs after a stressful event, such as a pregnancy, a sexual problem, or the death of a relative. Because many persons manage to keep their symptoms secret, there is often a delay of 5 to 10 years before patients come to psychiatric attention, although the delay is probably shortening with increased awareness of the disorder. The course is usually long but variable; some patients experience a fluctuating course, and others experience a constant one.
About 20 to 30 percent of patients have significant improvement in their symptoms, and 40 to 50 percent have moderate improvement. The remaining 20 to 40 percent of patients either remain ill or their symptoms worsen.

About one third of patients with Obsessive Compulsive Disorder have major depressive disorder, and suicide is a risk for all patients with Obsessive Compulsive Disorder. A poor prognosis is indicated by yielding to (rather than resisting) compulsions, childhood onset, bizarre compulsions, the need for hospitalization, a coexisting major depressive disorder, delusional beliefs, the presence of overvalued ideas (i.e., some acceptance of obsessions and compulsions), and the presence of a personality disorder (especially schizotypal personality disorder). A good prognosis is indicated by good social and occupational adjustment, the presence of a precipitating event, and an episodic nature of the symptoms, the obsessional content does not seem to be related to the prognosis.

1.6 TREATMENT

With mounting evidence that Obsessive Compulsive Disorder is largely determined by biological factors, classic psychoanalytic theory has fallen out of favor. Moreover, because Obsessive Compulsive Disorder symptoms appear to be largely refractory to psychodynamic psychotherapy and psychoanalysis, pharmacological and behavioral treatments have become common. But psychodynamic factors may be of considerable benefit in understanding what precipitates exacerbations of the disorder and in treating various forms of resistance to treatment, such as noncompliance with medication.

Many patients with Obsessive Compulsive Disorder tenaciously resist treatment efforts. They may refuse to take medication and may resist carrying out therapeutic homework assignments and other activities prescribed by behavior therapists. The obsessive-compulsive symptoms themselves, no matter how biologically based, may have important psychological meanings that make patients reluctant to give them up. Psychodynamic exploration of a patient’s resistance to treatment may improve compliance.
Well-controlled studies have found that pharmacotherapy, behavior therapy, or a combination of both is effective in significantly reducing the symptoms of patients with Obsessive Compulsive Disorder. The decision about which therapy to use is based on the clinician’s judgment and experience and the patient’s acceptance of the various modalities.

In the absence of adequate studies of insight-oriented psychotherapy for Obsessive Compulsive Disorder, any valid generalizations about its effectiveness are hard to make, although there are anecdotal reports of successes. Individual analysts have seen striking and lasting changes for the better in patients with obsessive-compulsive personality disorder, especially when they are able to come to terms with the aggressive impulses lying behind their character traits. Likewise, analysts and dynamically oriented psychiatrists have observed marked symptomatic improvement in patients with Obsessive Compulsive Disorder in the course of analysis or prolonged insight psychotherapy.

Supportive psychotherapy undoubtedly has its place, especially for those Obsessive Compulsive Disorder patients who, despite symptoms of varying degrees of severity, are able to work and make social adjustments. With continuous and regular contact with an interested, sympathetic, and encouraging professional person, patients may be able to function by virtue of this help, without which their symptoms would incapacitate them. Occasionally when obsessional rituals and anxiety reach an intolerable intensity, it is necessary to hospitalize patients until the shelter of an institution and the removal from external environmental stresses diminish symptoms to a tolerable level.

A patient’s family members are often driven to the verge of despair by the patient’s behavior. Any Psychotherapeutic endeavors must include attention to the family members through provision of emotional support, reassurance, explanation, and advice on how to manage and respond to the patient.
1.6.1 Pharmacotherapy

The efficacy of pharmacotherapy in Obsessive Compulsive Disorder has been proved in many clinical trials and is enhanced by the observation that the studies find a placebo response rate of only about 5 percent.

The drugs, some of which are used to treat depressive disorders or other mental disorders, can be given in their usual dosage ranges. Initial effects are generally seen after 4 to 6 weeks of treatment, although 8 to 16 weeks are usually needed to obtain maximal therapeutic benefit. Treatment with antidepressant drugs is still controversial, and a significant proportion of patients with Obsessive Compulsive Disorder who respond to treatment with antidepressant drugs seem to relapse if the drug therapy is discontinued.

The standard approach is to start treatment with an SSRI or clomipramine and then move to other pharmacological strategies if the serotonin-specific drugs are not effective. The serotonergic drugs have increased the percentage of patients with Obsessive Compulsive Disorder who are likely to respond to treatment to the range of 50 to 70 percent.

- **Serotonin-Specific Reuptake Inhibitors:** The Food and Drug Administration (FDA) have approved each of the SSRIs available in the United States – fluoxetine (Prozac), fluvoxamine (Luvox), paroxetine (Paxil), Sertraline (Zoloft) for the treatment of Obsessive Compulsive Disorder. Higher dosages have often been necessary for a beneficial effect, such as 80 mg a day of fluoxetine. Although the SSRIs may cause sleep disturbance, nausea and diarrhea, headache, anxiety, and restlessness, these adverse effects are often transient and are generally less troubling than the adverse effects associated with tricyclic drugs, such as clomipramine. The best clinical outcomes occur when SSRIs are used in combination with behavioral therapy.
**Clomipramine:** - Of all the tricyclic and tetracyclic drugs, clomipramine are the most selective for serotonin reuptake versus norepinephrine reuptake and are exceeded in this respect only by the SSRIs. The potency of serotonin reuptake of clomipramine is exceeded only by sertraline and paroxetine. Clomipramine was the first drug to be FDA approved for the treatment of Obsessive Compulsive Disorder. Its dosing must be titrated upward over 2 to 3 weeks to avoid gastrointestinal adverse effects and orthostatic hypotension, and like other tricyclic drugs, it causes significant sedation and anticholinergic effects, including dry mouth and constipation. As with SSRIs, the best outcomes result from a combination of drug and behavioral therapy.

**Other Drugs:** - If treatment with clomipramine or an SSRI is unsuccessful, many therapists augment the first drug by the addition of valproate (Depakene), lithium (Eskalith), or Carbamazepine (Tegretol). Other drugs that can be tried in the treatment of Obsessive Compulsive Disorder are venlafaxine (Effexor), pindolol (Visken), and the monoamine oxidase inhibitors, especially phenelzine (Nardil). Other pharmacological agents for the treatment of unresponsive patients include buspirone (BuSpar), 5-hydroxytryptamine (5-HT), L-tryptophan, and clonazepam (Klonopin).

### 1.6.2 Behavioral Therapy

Although few head-to-head comparisons have been made, behavior therapy is as effective as pharmacotherapies in Obsessive Compulsive Disorder, and some data indicate that the beneficial effects are longer lasting with behavior therapy. Therefore, many clinicians consider behavior therapy the treatment of choice for Obsessive Compulsive Disorder. Behavior therapy can be conducted in both outpatient and inpatient settings. The principal behavioral approaches in Obsessive Compulsive Disorder are exposure and response prevention. Desensitization, thought stopping, flooding, implosion therapy, and aversive conditioning has also been used in patients with Obsessive Compulsive Disorder. In behavior therapy, patients must be truly committed to improvement.
1.6.3 Psychotherapy

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1.6.4 Group Therapy: - Treating patients in a group setting is sometimes undertaken for various conditions. For example, patients with upsetting social anxiety are often treated in social skills groups. In some recent treatment programmers, patients suffering from compulsions have been successfully treated in groups; patients whose main problems are obsessions are more likely to benefit from individual treatment. Support groups for patient have been found to be of some benefit when used as an adjunct to individual therapy. Family members may also be included in the Obsessive
Compulsive Disorder family support groups. In recent years, self-help organizations have been running support groups for patients and families, and many have found these to be helpful.

1.6.5 Other Therapies

Family therapy is often useful in supporting the family, helping reduce marital discord resulting from the disorder, and building a treatment alliance with the family members for the good of the patient. Group therapy is useful as a support system for some patients.

For extreme cases that are treatment resistant and chronically debilitating, electroconvulsive therapy (ECT) and psychosurgery may be considered. ECT is not as effective as psychosurgery, but it should be tried before surgery. The most common psychosurgical procedure for Obsessive Compulsive Disorder is cingulotomy, which is successful in treating 25 to 30 percent of otherwise treatment-unresponsive patients. The most common complication of psychosurgery is the development of seizures, which are almost always controlled by treatment with phentoin (Dilantin). Some patients who do not respond to psychosurgery alone and who did not respond to pharmacotherapy or behavior therapy before the operation do respond to pharmacotherapy or behavior therapy after psychosurgery.

1.6.6 Cognitive Behavioural Therapy (Cognitive Behaviour Therapy)

Cognitive behavioural therapy is a practical, hands-on approach that helps people changes the way they feel by evaluating and changing the way they think and act. It is the combination of two different types of therapy: behaviour therapy and cognitive therapy.

Cognitive Therapy: Cognitive therapy was initially developed in the 1960s by Aaron Beck as a short-term method for treating depression by teaching people to recognize their dysfunctional thinking and think more rationally. Other researchers have created variations of cognitive therapy. Today, cognitive therapy and its variants are used to
treat conditions including Obsessive Compulsive Disorder, panic disorder, post-traumatic stress disorder, the eating disorders, and personality disorders (Beck 1995).

**Behaviour Therapy:** The work of Professor Hans Eysenck (1916-97) in London contributed to the development and acceptance of behaviour therapy as a major approach to certain psychological problems. In essence, he said that processes of learning acquire many unadaptive behavioural problems – and what a learning process has acquired can be unlearned. Unadaptive behaviour falls into two categories: cases of faulty unadaptive learning, such as irrational fears, or problems that arise because of a failure to learn adaptive behaviour. In either case, it should be possible to correct matters by applying the principles of learning. The faulty learning can be undone, and new learning can be promoted. Therefore, behaviour therapy concentrated on the problem of behaviour itself. It did not assume, as the then prevalent psychoanalytical approach did, that patient’s difficulties are symptoms of deeper unconscious complexes. Rather than attempting to unravel the putative deep causes, behaviour therapists worked directly on the problem behaviour. They concentrated more on the problem as it is now, and what factors are currently associated with it, rather than its past history. Of course, therapists need to know from the patient when the problem started, how it developed, and so on, but the main focus is on the problem as it is now, and therapist’s efforts are geared towards modifying this problem.

**1.6.7 Cognitive Behavioural Therapy and Obsessive Compulsive Disorder.**

Cognitive Behavior Therapy is a promising treatment; it is a psychotherapeutic approach, which addresses dysfunctional emotions, maladaptive behaviors and cognitive processes and contents through a number of goal-oriented, explicit systematic procedures. It is also self-help to the Person in future. The treatment found to be the most effective in successfully tackling Obsessive-Compulsive Disorder (Obsessive Compulsive Disorder) is a special form of talking therapy called Cognitive Behavioural Therapy (Cognitive Behavior Therapy). The principal aim of this therapeutic approach is to enable the person to become their own therapist and to provide them with the knowledge and tools to continue working towards complete recovery from Obsessive
Compulsive Disorder. Research has shown that Cognitive Behavioural Therapy significantly helps 75% of people with Obsessive Compulsive Disorder. In many cases, Cognitive Behavior Therapy alone is highly effective in treating Obsessive Compulsive Disorder, but for some people a combination of Cognitive Behavior Therapy and medication is also effective. Medication may reduce the anxiety enough for a person to start, and eventually succeed, in therapy. Cognitive Behavior Therapy makes use of two evidence-based behavior techniques, Cognitive Therapy (C) that looks at how we think, and Behavior Therapy (B), which looks at how this affects what we do. In treatment we consider other ways of thinking (C), and how this would affect the way we behave (B). Exposure and Response Prevention therapy (ERP) is used as part of the behavioural approach to help explore alternative ways to respond to the obsessional thoughts or doubts. The problem that Obsessive Compulsive Disorder creates is an increase in anxiety following an intrusive thought, whilst a normal response to an anxiety-provoking situation is for the anxiety to slowly decrease after the initial event. For someone with Obsessive Compulsive Disorder the anxiety is maintained and often increases, usually because of their overestimation of the perceived level of threat. What we also know from research is that almost everyone has intrusive thoughts that are either non-sensical or alarming. The aim of Cognitive Behavior Therapy is not about learning not to have these thoughts in the first place, because in essence, intrusive thoughts cannot be avoided. Instead it is about helping a person with Obsessive Compulsive Disorder to identify and modify their patterns of thought that cause the anxiety, distress and compulsive behaviors.

What therapy will teach the person with Obsessive Compulsive Disorder is that it’s not the thoughts themselves that are the problem; it’s what the person makes of those thoughts, and how they respond to them, that are the key to recovery from Obsessive Compulsive Disorder.

Cognitive Behavior Therapy is used successfully in many psychological problems, including other anxiety problems such as panic, post-traumatic stress disorder and social phobia. It also figures in treating eating disorders, addictions and psychosis. The basic principles of Cognitive Behavior Therapy are the same across all these different
problems, and across all aspects of Obsessive Compulsive Disorder, regardless of the form the illness takes.

A good way of understanding how different responses to thoughts can affect the way we behave can be demonstrated in the example below, which sufferers and non-sufferers alike will be able to relate to.

It’s the middle of the night, you’re in bed. You hear a noise from downstairs. You might think: ‘It’s the stupid cat again’, feel angry, put your head under the pillow and try to go back to sleep.

You might think: ‘It’s my partner coming in, I haven’t seen them all day!’ , feel happy and get out of bed to say ‘hello’. You might think: ‘It’s a burglar’, feel frightened and call the police.

What this example shows is that the same event can make people feel completely different emotions (angry, happy, anxious), and result in them behaving in very different ways, due to their different beliefs about the event. Cognitive Behavior Therapy is based on this intuitive understanding of how we all think.

So how does this help us understand how to treat Obsessive Compulsive Disorder? We believe that Obsessive Compulsive Disorder works in exactly the same way: A disturbing image crosses your mind: you throwing your dog under a train.

You might think: ‘Damn it, that’s made me forget what I was going to say’ and feel angry, and frown.

You might think: ‘Wow, what a creative and funny person I am! I’m going to write that down’ and feel happy that your mind can be so creative. You might think: ‘Because I’ve thought that, I must want it to happen, therefore I must be sure I try to undo it’. You then feel anxious, check, seek reassurance and ultimately avoid taking the dog near the train track.

In summary, it’s not the thoughts themselves that are the focus of treatment; it’s what we make of those thoughts in the first place.
In treatment for Obsessive Compulsive Disorder, one of the first things a person will be asked to do is to think of a recent specific example of when the Obsessive Compulsive Disorder was really severe. They will be asked to go into a lot of detail, and try and understand what thought(s) (or doubts, images or urges) popped into their head at this time.

People with Obsessive Compulsive Disorder often ask if treatment can help them get rid of these intrusive thoughts, as they are so distressing and horrible. But if you instead consider whether all intrusive thoughts are always horrible you will see that they are not. Usually people can think of an occasion when they suddenly had a thought that was helpful, such as suddenly remembering a friend’s birthday is coming up, or having a memory of a lovely holiday pop into their head. We can conclude from this that getting rid of intrusive thoughts themselves isn’t a realistic, or sometimes, desirable goal. It is also worth remembering that everyone has all sorts of intrusive thoughts – including the nasty ones: thoughts of harm coming to people, images of violence, urges to check things, doubts about whether they have done something. The difference with other people is that their intrusive thoughts do not become bothersome.

- **Challenging the meaning attached to the thoughts** In Cognitive Behavior Therapy the person with Obsessive Compulsive Disorder will explore alternative meanings or beliefs about the intrusive thoughts and rituals in all their guises (for example washing, checking, writing lists, tapping, touching, repeating, cleaning, trying to get a ‘just right’ feeling, praying) and will learn what it is that ultimately keeps alive the meanings they attach to such thoughts and rituals.

So during the first few sessions a good therapist should spend time making sense of how the Obsessive Compulsive Disorder works and what keeps it going. The idea and reason behind this is that if we can understand the factors that keep a problem alive, we can then take the next step, which is to think about alternative ways of viewing the problem and what we can then do to change it.
Therefore in Cognitive Behavior Therapy we look at how Obsessive Compulsive Disorder convinces you that the rituals and compulsions performed are necessary, in order to prevent something bad happening. If such a bad outcome were to be true as a result of the thought, the sufferer would be convinced it was entirely their fault and responsibility. We also look at the possibility that Obsessive Compulsive Disorder is a liar. All the sufferer's coping strategies have come about in the first place to make them feel safer and less anxious, when in fact they do the exact opposite, they make the person feel unsafe and scared. Even if they provide temporary relief from anxiety, all these rituals make the meaning attached to those intrusive thoughts, images, urges and doubts feel even stronger, therefore it becomes necessary for the sufferer to keep doing the rituals continuously. Ultimately this makes the thoughts seem even more real, and like there is even more truth in them.

**Figure No. 1.6 Cognitive model of the persistence of anxiety: the “vicious flower”**

![Cognitive model of the persistence of anxiety](image)

The cyclical nature of the problem can be illustrated by drawing a diagram of how it works - we sometimes call it the ‘vicious flower’ – one of Professor Paul Salkovskis’s diagrams shows the general idea.

So how do we deal with all these rituals? Here are some common ones; along with an idea of possible ways we might tackle them in Cognitive Behavior Therapy:

For example, if the Obsessive Compulsive Disorder problem is checking, the sufferer might be asked to try ‘behavioural experiments’ to find out what happens when they
don’t check. A key stage in the evolution of Cognitive Behavior Therapy was the development of ‘Exposure and Response Prevention (ERP)’, which involves being exposed to whatever it is, that makes a person feel anxious, without checking or carrying out other rituals. Cognitive Behavior Therapy then goes beyond this, by using what we call ‘behavioural experiments’ which find out what happens when a sufferer doesn't check or perform their rituals. Rather than just riding out their anxiety in the feared situation (as in ERP), it goes further by testing out the sufferer's belief that they could ultimately be responsible for harm by not checking or performing their rituals. The therapist will always acknowledge that there is a risk that something bad will happen if the sufferer doesn’t check, but it is the perception of the level of risk that ultimately drives the Obsessive Compulsive Disorder, by magnifying it to be greater than it actually is. The one guarantee is that with continued checking the Obsessive Compulsive Disorder will always remain a problem.

Obsessive Compulsive Disorder also often tells people to avoid all sorts of things (for example public toilets, children’s playgrounds, people with diseases etc), but by avoiding such situations the sufferer never has the chance to find out what really would happen. So in Cognitive Behavior Therapy, people are asked to consider doing the opposite to avoiding the situation (for example if Obsessive Compulsive Disorder has made a person believe that they are at risk of dying from contamination from germs – in treatment the therapist and patient might put their hands down the toilet). This behavioural experiment allows the person to find evidence for themselves about whether Obsessive Compulsive Disorder has been lying and whether they have been needlessly avoiding situations for no reason at all.

Avoiding thoughts is another common example of avoidance – but this is impossible. In fact when we experiment with this idea in treatment, we find out that trying not to think of something makes it worse. Remember the ‘pink fluffy bunny rabbit’ example? When asked to try not to think of pink fluffy bunny rabbits or their fluffy pink faces… you usually can't think of anything else but pink fluffy bunny rabbits with fluffy pink faces! If you have a thought of harming children, Obsessive Compulsive Disorder will make you believe that you will do it, and it makes sense to
then try and banish those horrible thoughts from your mind. But ultimately it is unhelpful to then challenge the thought and look for evidence to prove it untrue. Instead, in Cognitive Behavior Therapy, we might actually bring on those thoughts – perhaps going to a children’s playground and deliberately thinking of harm. Again with the ultimate aim of proving Obsessive Compulsive Disorder to be a liar.

If a person believes that they are responsible for harm, or capable of being a paedophile, or that they can’t be trusted to lock their house, it seems like a good idea to seek reassurance and ask someone close to you to tell you otherwise. Unfortunately this reassurance seeking ends up strengthening the belief that you really are responsible or capable of such things, thus keeping the anxiety high and driving the Obsessive Compulsive Disorder cycle. Cognitive Behavior Therapy will experiment with this by asking the sufferer not to ask for reassurance, and then seeing what happens to the obsessional belief.

Obsessive Compulsive Disorder tunes a person in to risk. It makes them more likely to spot ‘risky’ situations – and to notice those intrusive thoughts. This makes it seem as if the world really is a dangerous place, and increases anxiety. Cognitive Behavior Therapy will consider the possibility that there is a risk attached to most things, but experiment with whether being on ‘full alert’ the whole time makes the Obsessive Compulsive Disorder belief weaker to her.

On ‘Who wants to be a Millionaire’, when Chris Tarrant says ‘Are you sure? Is that your final answer?’ – does that make the contestant feel less anxious? Or does that questioning make them feel less sure, and more anxious? In fact for these contestants, their sense of belief in having the right answer suddenly disappears when they start asking themselves, “is that definitely correct?” Whereas before Chris Tarrant asked them if they were sure, they might well have been 90-100% certain of their answer, this level of belief drops to 75% the moment Chris Tarrant asked them if they are sure they are right. The more they question themselves, the less certain they are.
Obsessive Compulsive Disorder often makes people mentally check or argue with themselves, and the person with Obsessive Compulsive Disorder will be asked to try not to engage in these arguments, and see what happens.

These types of behavioural approaches deliberately create anxiety, but at a level the person with Obsessive Compulsive Disorder is ready to tolerate, often in a very structured and hierarchical step-by-step approach, starting with small exposure exercises, building up to much more difficult ones. So one of the first steps the person with Obsessive Compulsive Disorder may be asked to do in therapy – and in fact one which they could start before therapy begins – is to describe the obsessions and compulsions and rank them with the most severe ones at the top, and the least severe at the bottom. This is called the graded hierarchical approach.

There is another treatment approach, once commonly used but less so now, where a person would be exposed to their worst fears very early on, an approach called ‘flooding’.

Flooding is the treatment approach that involves immersing the person with Obsessive Compulsive Disorder in the situation they fear the most and staying in the situation until the anxiety becomes less bothersome.

Perhaps a good way to understand these two approaches is an analogy that involves a swimming pool. Have you ever jumped straight into the deep end and had the shock of the cold water take you by surprise? Every inch of your body is momentarily shocked by the cold and your body is shaking and struggling to stay afloat whilst it tries to acclimatise to the water? Flooding is very much like that. It involves jumping in at the deep end of the swimming pool, and staying there until your anxiety, or in this case your body, gets used to the water temperature. Using the same analogy, graded step-by-step exposure would involve slowly walking into the swimming pool from the shallow end, slowly placing that first toe, and then the foot, into the water, and one step at a time placing the next foot up to your ankle, then your knees, slowly getting used to and acclimatising to the temperature before taking another step. Slowly getting, deeper
and deeper but at a much more tolerable pace, which does not leave your body shaken in the same manner jumping in at the deep end would.

Although flooding can work if it can be tolerated by the sufferer, and although it is the quickest way to tackling Obsessive Compulsive Disorder, for most people the graded step-by-step approach is much more tolerable and effective.

But equally, it is important to remember that before you attempt to swim, you must first learn the cognitive theory, otherwise you will just sink. So in treatment, both the Cognitive and Behavioural aspects are equally important.

Being asked to face your fears is perhaps one of the bravest aspects of treatment, and this is where the approach of the therapist will be most valuable in helping a person understand the cognitive reasons behind the exercise, and being there to help encourage and motivate them to be able to face the challenges it involves. If the therapist actually participates in the exercises too, this helps build up trust and confidence in what they are asking the person with Obsessive Compulsive Disorder to do. Generally, people find that the exposures are not as difficult as they imagined, and their anxiety and fears fade away much quicker than they ever imagined. This helps boost their confidence and makes tackling more difficult challenges much easier.

When therapeutic exposures are repeated over time, the associated anxiety shrinks until it is barely noticeable or even fades entirely. Effective Cognitive Behavior Therapy leads to ‘habituation’ where the person with Obsessive Compulsive Disorder will learn that nothing bad happens when they stop performing their compulsive rituals.

Will Cognitive Behavior Therapy be able to help your form of Obsessive Compulsive Disorder, without obvious physical compulsions? Perhaps you don’t check, or wash, or count, or do any of the things that people readily think of as part of Obsessive Compulsive Disorder. But remember, Obsessive Compulsive Disorder is a chameleon – it appears in many forms in different people. One of the great things about Cognitive Behavior Therapy is that however the problem manifests itself, now or in the future, the same tools are useful in getting rid of it.
One important factor in the effectiveness of Cognitive Behavior Therapy is the ability of the treatment provider. In some cases, a course of Cognitive Behavior Therapy will not always be effective the first or even second time and if this happens you should consider seeking a referral to an Obsessive Compulsive Disorder specialist, or similar. Cognitive Behavior Therapy should perhaps be considered like learning to drive, not everyone passes their test first time and sometimes a person may need several courses of lessons with different instructors (therapists) who will teach them the same basics of pressing the pedals (Cognitive Behavior Therapy) but in slightly different ways.

Although many people do make successful long-term progress in treating their Obsessive Compulsive Disorder, sometimes setbacks do happen. So should someone ever experience a setback after successful tackling their Obsessive Compulsive Disorder, NICE recommend that healthcare professionals see you as soon as possible rather than putting you back onto a lengthy routine waiting list.

Remember, Obsessive Compulsive Disorder is ‘Just a Thought’ and what Cognitive Behavior Therapy will teach people is that it’s not the thoughts themselves that are the problem; it’s what people make of those thoughts and how they respond to them that is the key to recovery from Obsessive Compulsive Disorder.

➢ Obsessive Thinking, Worry, and Cognitive Behaviour Therapy

- Why Worry? Worry is an anxious preoccupation with an anticipated negative event. Over the course of evolution, worry helped us adapt by directing awareness to true problems that once identified can be effectively addressed. In this way worry is effective in managing challenges of your everyday life.

- Unhealthy Worry For some people, this process breaks down. Their minds become trapped in an endless process of “figuring it out.” They are plagued by thoughts and images of disastrous outcomes that in reality may never come to be. Worriers are particularly challenged by problems that have no clear solution.
Instead of accepting and managing these difficult realities, they are viewed as evidence of the futility of even trying to work things out.

- **Obsessive Thinking** Unhealthy worry is part of a broader problem called obsessive thinking. Obsessive thinking is an inability to gain control over recurrent, distressing thoughts, images. These thoughts and images are embedded in a complex network of feelings, sensations, and at times, behavioral rituals and routines. Brain imagings studies indicate that obsessive thinking is associated with a neurological dysfunction of unknown cause those forces thoughts into repetitive loops. Obsessive thinking is like a hamster wheel in your brain, with a parade of different animals entering and exiting over time.

- **Rumination** Obsessive worry is focused on future outcomes. Rumination, another form of obsessive thinking, is the uncontrollable preoccupation with the past. Rumination is experienced as guilt, regret and anger, over perceived mistakes, losses, slights, actions taken or not taken, opportunities forever lost, with irreversible, catastrophic results. Condemning, all-or-none criticism, and the overwhelming belief that if things had been different then existing and future misery could be avoided accompany rumination.

- **The Damage Done** Obsessive thinking intensifies and prolongs distressing emotions. For example, worry reinforces anxious feelings – you literally scare yourself – which, in turn, only leads to more worry. The process can extend into anxious periods lasting hours, days or weeks, at times “spiraling” into panic attacks and emotional “spikes” of anger, guilt and shame. Obsessive thinking limits effective problem solving, and promotes procrastination, avoidance and withdrawal, only resulting in further problems. Obsessive thinking plays a prominent role in mood disorders, including dysthymia, major depression, bipolar disorder, and is the defining symptom of Generalized Anxiety Disorder (GAD), Obsessive-Compulsive Disorder (Obsessive Compulsive Disorder), Panic Disorder, and many other psychological conditions.
• **Attempts to Control Obsessive Thinking “Stopping” the Thoughts** Obsessive thinking is difficult if not impossible to control. If you are prone to obsessive brain patterns, you’ve likely tried forcing the unwanted thoughts out of your mind. Despite its intuitive appeal, evidence shows that this strategy rarely works. In fact, research shows that attempts to “force away” obsessive thoughts may only intensify obsessive thinking.

• **Rituals** Temporarily “Soothing”, “neutralizing” cognitive-behavioral routines often develop as natural attempt to control onslaught obsessive thinking. Research shows that such routines, or “rituals”, only serve to reinforce obsessive thinking.

• **Cognitive Behavior Therapy: Understanding the Problem** Cognitive-behavior therapy begins with the scientific understanding of obsessive thinking. The goal is to dispel misconceptions that may fuel the problem, and to equip you with the knowledge, to begin your recovery. Rather than frustrating you with the unrealistic goal of stopping the thoughts, cognitive-behavior therapy helps by weakening the connection between obsessive thinking and the rest of your waking life. In other words, faced with the reality that there is no on/off switch, Cognitive Behavior Therapy turns down the volume. The strategies are designed to minimize engagement in the obsessive process, reducing attention to its useless content, cutting off its fuel supply, and reducing the intensity and urgency of its call, while working to developing new, more effective sources of emotional reward.

• **Cognitive Restructuring:** To step back from emotional thinking, engage a wise mind that is at once informed by your feelings, and grounded by a healthy appreciation of objective observation and reason.

• **Acceptance-Mindfulness:** An emotionally grounding starting point, is the emotionally sober determination of which elements of the problem can be effectively changed, and which are fixed and enduring enough to repel the best attempts at change. To change requires courage, and emotional fortitude, to persist in practicing new ways of thinking and behaving, and to accept, that is, to adjust to
immovable challenges, requires the same courage, fortitude, and persistent practice. Mindfulness is the experiential practice of acceptance – exercising the mental muscles needed to engage effective cognitive-affective-behavioral routines persistently over time.

- **Attention Shifting:** This strategy simultaneously encourages the application of a balanced, reasonable alternative thought, and the practice of “letting go” of obsessive content. Rather than attempting to “stop” the obsessive process, it works by shifting your attention to a predetermined thought and/or action. For example, the statement “these are just thoughts, they are not helping but are only hurting me”, or “I don’t know what will happen in my future, but the probability of ________ occurring is slim”, followed by three deep breaths and return to the task at hand.

- **Relaxation:** Practice exercises to let go, physically, in your body, and emotionally, in your mind.

- **Repeated Exposure:** Exposure for panic attacks, phobias and Obsessive Compulsive Disorder is the most reliable treatment in the behavioral health field. It is used to “desensitize” (habituate) the person to fear, distressing situations, thoughts, feelings and sensations. Exposure is a “paradoxical” approach, where you go against instinct by “facing” (opening up to, accepting, surrendering to) the object or irrational distress.

- **Behavioral Activation:** The ultimate goal of treating obsessive thoughts is to “get out of your head” and into your life. Behavioral activation is focused on just that – setting specific goals to engage in meaningful, healthy behaviors, as opportunities to practice attention shifting and application of other cognitive behavioral techniques.

Washing and cleaning rituals are the most well-known and widely recognized symptom of Obsessive Compulsive Disorder. People with this type of Obsessive Compulsive Disorder can be described as perpetually engaged in compulsive acts of decontamination. People who compulsively wash and clean can be divided into two groups: (a) those who are tying to prevent being harmed or spreading harm to others via
contamination, and (b) those who feel discomfort or contaminated by specific substances, but are not worried about harm.

The first group of patients is usually worried about coming down with an illness or disease from contamination, which in some cases may involve responsibility for spreading contamination to others. Washing rituals are performed in an attempt to prevent this perceived danger. Individuals in the second group tend to have fewer identifiable obsessions and engage in cleaning compulsions merely to relieve the discomfort associated with feeling dirty. People with this type of Obsessive Compulsive Disorder typically have very strong disgust reactions.

**Washing Compulsions**

People with contamination fears will typically engage in excessive washing in order to remove dirt and germs, or just to feel clean. This often involves excessive or repeated hand washing. Hand washing may be done in a ritualized manner, where the person cleans each finger individually and sometimes even under each fingernail. It is not uncommon for people with this type of Obsessive Compulsive Disorder to have hands that are red and chapped, and they may even bleed. Once hands are clean, the person will then carefully turn off the tap with another object, such as the towel or napkin, to avoid recontamination of the hands. Compulsive hand washers may also engage in excessive use of hand sanitizers between trips to the sink. Excessive or ritualized showering, bathing, tooth brushing, grooming, or toilet routine. Other measures to prevent or remove contact with contaminants. (i.e. wear gloves)

**Cleaning Compulsions**

People with contamination Obsessive Compulsive Disorder may spend a lot of time cleaning of household items or other inanimate objects. For example, someone with this type of Obsessive Compulsive Disorder may wash their shoes, credit cards, cell phone, or other things that may have come into contact with something that may be considered dirty or contaminated.
Avoiding Contaminants
People with contamination concerns will often go to great lengths to avoid getting dirty. They may avoid touching their shoes by pushing the heel of one shoe down with the other. They may use a sleeve or tissue to open a doorknob.

Compulsive Checking
Checking rituals can be a result of all types of obsessions, including fears of harming accidentally, fears of harming impulsively, or sexual obsessions. The purpose of compulsive checking is to reduce distress associated with uncertainty or doubt over feared consequences for oneself or others. For example, a person who worries about causing harm by not being careful enough, may have the thought that if they check that the door is locked, they will be assured that no one will break in.

Whereas some checking is cued by specific situations (e.g., leaving the house) and reminders (e.g. light switches), in other instances it is performed in response to random thoughts that just pop into the mind and are considered dangerous. People with these types of obsessions, may believe that if they think of a bad event, it is more likely to happen.

Types of Checking
Checking locks. People with Obsessive Compulsive Disorder have been known to repeatedly check locks to ensure that they are properly bolted. The person who checks knows that they have checked the lock, but feels it is important to check again just in case. The person may check locks on doors, they may check window latches, or car door locks. The fear is usually that someone may break in and steal possessions, or cause harm, and that the person with Obsessive Compulsive Disorder would be responsible for not having checked the lock initially. This type of compulsion is particularly common when someone has Obsessive Compulsive Disorder that is triggered by a traumatic event such as rape or burglary.

Checking stoves, appliances, and switches. People with Obsessive Compulsive Disorder often check stoves, ovens and toasters to ensure that they have not left on anything that could cause a fire. The person may repeatedly check to make sure the appliance is off or unplugged, and is no longer hot before they feel safe.
Usually this fear applies to other appliances that can get hot such as a blow dryer or curling iron. In many cases people worry about light switches, electrical outlets and light sockets being a cause of fire as well. If the person cannot be sure that the items are in the off position, the person will obsess that a spark or a faulty wire could cause a fire.

**Checking related to harming others.** Because people with Obsessive Compulsive Disorder tend to feel overly responsible for causing harm, it is not uncommon for them to repeatedly check to ensure that they have not accidentally caused harm to others. One common example of this type of checking involves fear of running another person over while driving. The person with Obsessive Compulsive Disorder may hit a bump in the road and then worry about whether or not the bump was the sound of the car running over another person or a small child. Even though logically, the person with Obsessive Compulsive Disorder knows that if a person had been hit, there would be the sound of screaming and sight of blood, the Obsessive Compulsive Disorder torments the sufferer of thought of "what if..." So the person with Obsessive Compulsive Disorder will then stop the car and look under the wheels or turn around to inspect the road to reassure him or herself that no one was harmed.

**Checking related to harming self.** Some people with Obsessive Compulsive Disorder worry that they may have harmed themselves without knowing it. They may check their bodies for cuts and bruises to be sure.

**Checking surrounding catastrophe.** These people will go to great lengths to make sure that nothing terrible has happened that they may be responsible for. This includes checking the newspapers for information about disasters (e.g. airplane crash) or obituaries for deaths.

**Checking for mistakes.** People with Obsessive Compulsive Disorder are often concerned about having made an error that will result in terrible consequences. As a result they may repeatedly review homework, checks, and forms. They may open sealed letters to make sure they completed everything correctly. They may review emails multiple times both before and after sending.

**Checking tied to somatic obsessions.** People with Obsessive Compulsive Disorder may fear they are coming down with a dreaded disease. In such cases they
may repeatedly check their body for signs of illness. For example, they may purchase a blood pressure cuff and repeatedly check their blood pressure. They may examine their skin for signs of blisters or redness. They may take their temperature to ensure it is not elevated.

**Repeating**
- Re-reading the same passage in a book repeatedly
- Re-writing (including excessive correcting of writing)
- Repeat routine activities (e.g., in/out door, up/down from chair)
- Saying the same thing over and over

**Compulsive Counting**
Compulsive counting is a common symptom of obsessive-compulsive disorder. People with counting compulsions may count because they feel that certain numbers have a special significance, and therefore specific actions must be performed a certain number of times. For example many people with Obsessive Compulsive Disorder feel that the number four is especially significant, and will therefore do things in sets of fours. For example if they smoke one cigarette, they may feel a sense of incompleteness unless they smoke three more. So they will count the number of cigarettes to be sure they have met the numerical goal.

People with counting compulsions may also count without thinking about a specific number. They might count their steps when walking, count tiles on the ceiling, or count cars driving past. The counting may be mental or aloud.

People with counting obsessions do not always have a reason for counting. Even though someone who has contamination fears often knows their washing concerns are overboard, they usually feel there is a chance the fear is somewhat based on reality. With numbers, the Obsessive Compulsive Disorder does not always activate because it is worried about a certain outcome. Often taking 4 steps within say one block on the sidewalk, or looking away from a clock at a certain number may just feel right, rather than be driven by fear. Often people with Obsessive Compulsive Disorder will have a primary subtype, i.e. sexual obsessions, but will have the numbers as more of a secondary problem. In cases like this, it is not as stressful or intrusive.
Even though Obsessive Compulsive Disorder is often illogical, many fears seem very logical in the mind of the sufferer, with seemingly very clear events leading straight to why a fear is valid and true. Unless very severe, adults with numerical obsessions usually realize there is no basis to the number fears (unless perhaps driven by religious fears over evil numbers, e.g. 666). Nonetheless, number fears can enter the mind and say look away from the clock at 12:11 or your family will die of cancer. Maybe the mind said 12:11 because when you add the numbers it comes out to 4 and just feels right. In a case like this, the Obsessive Compulsive Disorder sufferer will say to themselves, that it is ridiculous, but then the Obsessive Compulsive Disorder will say yes, but just in case look away at this time. If the person looks away at a bad time, the Obsessive Compulsive Disorder may pester to keep looking until an acceptable number is found. The person may even have to make a choice. The Obsessive Compulsive Disorder can say, look away at 12:56 and your family will die of cancer, but look away at 1:07 and you will go blind. One may then choose the 1:07 time just in case, to protect ones family, but will still be dealing with the fear of going blind. In this case they might take the blind sacrifice for their family, or spend a lot of time looking until a suitable look away number can be found.

Although a person with Obsessive Compulsive Disorder may realize this is just the Obsessive Compulsive Disorder, they continue to count or heed specific special numbers adjust in case€ and why tempt karma. These cases add up greatly with Obsessive Compulsive Disorder, and reinforcing the checking just makes the Obsessive Compulsive Disorder stronger. Which is why a sufferer may eventually become severe and consumed with counting rituals all day. If numbers are secondary to other Obsessive Compulsive Disorder concerns, these fears atop of a brain that already is overtaxed can be the final straw.

**Typical types of counting**

Counting steps, counting items, counting aloud, Mental counting, Counting numbers on devices (i.e. on a digital clock, the run time on the DVD player while trying to watch a movie, etc.)
Mental Compulsions

Although obsessions without overt rituals are now considered relatively common among people with Obsessive Compulsive Disorder, this Obsessive Compulsive Disorder type has generally been understudied and until recently has been considered resistant to treatment. Beliefs regarding the importance of thoughts and the need to control them are commonly reported by people with this type of Obsessive Compulsive Disorder. The meanings associated with unwanted thoughts may be related to views of self, i.e. "Having a bad thought means I am a bad person". The distressing thoughts are usually unacceptable or taboo in nature (sexual, harming, religious thoughts). Rather than perform an overt ritual, such people will engage in covert rituals and mental neutralizing. This might include repeating silent prayers, replacing "bad" thoughts with "good" thoughts, or erasing unpleasant mental images. These mental compulsions result in the same temporary relief from anxiety, and are thus equivalent to more overt rituals.

Common mental rituals

• Special words, images, numbers, repeated mentally to neutralize anxiety, Special prayers (short or long) repeated in a set manner, Mental counting, Mental list making, Mental reviewing (e.g. reviewing conversations or actions), Mental erasing of unwanted mental images, Mental un-doing.

• Figure No. 1.7 Handout for symptom list (stimulus hierarchy)
A four-step self-treatment method to change your Brain chemistry by Jeffrey M. Schwartz, M.D with Beverly Beyette.

In recent years, there have been major advances in treating this condition. More than two decades of research by behavior therapists have documented the effectiveness of a technique called exposure and response prevention. The use of this technique involves systematic exposure to stimuli that bring on Obsessive Compulsive Disorder symptoms, such as having a person with Obsessive Compulsive Disorder touch a toilet seat or other objects that he or she fears are contaminated, and cause the person to have obsessions and compulsions. The therapist then enforces extended periods during which the person agrees not to respond with compulsive behaviors. These periods, in turn, cause tremendous amounts of anxiety that last an hour or more and call for a significant amount of assistance by a trained therapist. As the therapy progresses, the intensity of the anxiety decreases, and the person gains much better control over the Obsessive Compulsive Disorder symptoms.

At UCLA School of Medicine, where we have been studying Obsessive Compulsive Disorder for more than a decade, we have developed a simple self-directed cognitive-behavioral therapy to supplement and enhance this process. We call it the Four-Step Self-Treatment Method. By teaching people how to recognize the link between Obsessive Compulsive Disorder symptoms and a biochemical imbalance in the brain, we were able to develop this method that very effectively treats persons with Obsessive Compulsive Disorder solely with behavior therapy. You will learn to fight off those urges and redirect your mind to other, more constructive behaviors.

It has scientific evidence that cognitive behavioral therapy alone actually causes chemical changes in the brains of people with Obsessive Compulsive Disorder. They have demonstrated that by changing your behavior, you can free yourself from Brain Lock, change your brain chemistry, and get relief from Obsessive Compulsive Disorder’s terrible symptoms. The end result: increased self-control and enhanced self-command, resulting in heightened self-esteem. Knowledge, as they say, is power. There is a huge difference in the impact an obsessive thought or urge has on a trained mind compared to what it has on an untrained mind. Using the knowledge that you will gain by learning the four steps, you will not only have a powerful weapon in your battle
against your unwanted thoughts and urges, but you will empower yourself in a much broader sense. You will take a big step toward strengthening your ability to attain your goals and improve the quality of your day-to-day life. You will develop a stronger, more stable, more insightful, calmer, and more powerful mind. If people with Obsessive Compulsive Disorder can do so, it is highly probable that those with a wide variety of other problems of different degrees of severity can, too.

Other disorders include:

- Uncontrolled eating or drinking
- Nail biting
- Hair pulling
- Compulsive shopping and gambling
- Substance abuse
- Impulsive sexual behaviors
- Excessive ruminating about relationships, self-image, and self-esteem.
- The four steps can be used to help you control almost any intrusive thought or behavior that you decide you want to change.
- The four-step Self-Treatment Method is a way of organizing your mental and behavioral responses to your internal thought processes. Rather than just acting impulsively or reflexively, like a puppet, when unwanted thoughts or urges intrude, you can train yourself to respond in a goal-oriented manner and can refuse to be sidetracked by self-destructive thoughts and urges.

We call these steps the four R’s:

Step 1: RELABEL
Step 2: REATTRIBUTE
Step 3: REFOCUS
Step 4: REVALUE

In Step 1: Relabel, you call the intrusive thought or urge to do a troublesome compulsive behavior exactly what it is: an obsessive thought or a compulsive urge. In this step, you are learning to clearly recognize the reality of the situation and not be
tricked by the unpleasant feelings Obsessive Compulsive Disorder symptoms cause. You develop the ability to clearly see the difference between what’s Obsessive Compulsive Disorder and what’s reality. Instead of saying, “I feel like I need to wash my hands again, even though I know it doesn’t make any sense,” you start saying “I am having a compulsive urge. That compulsion is bothering me. That obsessive thought is hounding me.”

The question then arises, “Why does this keep bothering me?”

In Step 2: Reattribute, you answer that question. You say, “It keeps bothering me because I have a medical condition called Obsessive Compulsive Disorder. I am having the symptoms of a medical problem. My obsessions and compulsions are related to a biochemical imbalance in my brain.” Once you realize this fact, you begin to ask yourself, “What can I do about it?”

In Step 3: Refocus; you turn your attention to more constructive behaviors. By refusing to take the obsessions and compulsions at face value – by keeping in mind that they are not what they say they are, that they are false messages – you can learn to ignore or to work around them by Refocusing your attention on another behavior and doing something useful and positive. This is what I call “shifting gears.” By performing an alternative, wholesome behavior, you can actually repair the gearbox in your brain. Once you learn how to refocus in a consistent way, you will quickly come to the next step.

In Step 4: Revalue, you revalue those thoughts and urges when they arise. You will learn to devalue unwanted obsessive thoughts and compulsive urges as soon as they intrude. You will come to see intrusive Obsessive Compulsive Disorder symptoms as the useless garbage they really are.

The Four Steps work together. First, you RELABEL: You train yourself to identify what’s real and what isn’t and refuse to be misled by intrusive destructive thoughts and urges. Second, you REATTRIBUTE: You understand that those thoughts and urges are merely mental noise, false signals being sent from your brain. Third you REFOCUS: You learn to respond to those false signals in a new and much more constructive way, working around the false signals by refocusing your attention on more constructive behavior to the best of your ability at that moment. This is where the hardest work is
done and where the change in brain chemistry takes place. By expending the effort it
takes to refocus, you will actually by changing how your brain works in an extremely
healthy and wholesome way. Finally, the real beauty of the Four-Step Method is seen in
the REVALUE step, when the whole process becomes smooth and efficient, and the
desire to act on unwanted thoughts and urges has been overcome to a significant
degree. You will have learned to view those troublesome thoughts and urges as having
little or no value and, therefore, your obsessions and compulsions will have much less
impact on you. Things come together very quickly, resulting in an almost automatic
response. “That’s just a senseless obsession. It’s a false massage. I’m going to focus my
attention on something else.” At this point, the automatic transmission in your brain
begins to start working properly again.

Once people learn to perform the Four Steps on a regular basis, two very positive things
happen. First, they gain better control over their behavioral responses to their thoughts
and feelings, which, in turn, makes day-to-day living much happier and healthier.
Second, by altering their behavioral responses, they change the faulty brain chemistry
that was causing the intense discomfort of their Obsessive Compulsive Disorder
symptoms. Since it has been scientifically demonstrated that the brain chemistry in this
serious psychiatric condition is changed through the practice of the Four Steps, it is
likely that one could also change one’s brain chemistry by altering responses to any
number of other behaviors or bad habits through using the Four Steps. The result could
be a lessening of the intensity and intrusiveness of these unwanted habits and
behaviors, making them easier to break.

FEAR THERMOMETER: It is a tool for rating the anxiety associated with
specific Obsessive Compulsive Disorder symptoms. It is important for the patient
to be able to distinguish between levels of anxiety when participating in E/RP
tasks, since the patient must tolerate elevated levels of discomfort and stay with
the experience until the discomfort level decreases significantly. The fear
thermometer provides the patient with a tool for measuring (or rating) anxiety or
other dysphoric affects. The fear thermometer is also used during exposure tasks
to measure the patient’s anxiety until it attenuates, which in turn documents the
success of the treatment strategy. Used as a numerical scale, the fear thermometer also helps the patient rank specific Obsessive Compulsive Disorder symptoms according to their potency or difficulty when presented as targets for E/RP. The fear thermometer helps the patient be more realistic about his or her probable responses to Obsessive Compulsive Disorder triggers (i.e., all fear isn’t absolute terror and all anger isn’t necessarily rage). Since Obsessive Compulsive Disorder fears decrease with treatment, fear thermometer ratings for items remaining on the stimulus hierarchy may need to be updated.

**Figure No. 1.8 Handouts of Map figure and Fear Thermometer**

- **THOUGHT STOPPING:** Thought stopping is a technique that can be used to interrupt and sometimes stop obsessions and mental rituals (Emmelkamp, Bouman, & Scholing, 1989). The technique, which is simple to implement, involves jerking attention off Obsessive Compulsive Disorder by introducing a powerful competing stimulus. Thought stopping has two basic components: 1) loudly shouting “Stop!” while 2) simultaneously snapping a
rubber band once against the left wrist. The purpose of this somewhat unusual practice is to momentarily “startle the brain” and interrupt the obsessive thought, so that the child can interject the “tool kit” strategies. For example, immediately following the “Stop,” the child might tell herself that her brain is playing tricks on her again and that the worry thoughts she is experiencing are unimportant and can safely be ignored. Next, she would engage her mind on something to compete with the obsessive thought, such as a long math problem, remembering a recipe, or reading a funny story. After the obsession has been interrupted, the patient should then implement his or her standard cognitive strategies since the usually momentary distraction offered by thought stopping would not offer complete respite from Obsessive Compulsive Disorder. If the obsession returns, the process is repeated until the obsession ends.

Figure No. 1.9 Daily Self-Monitoring Log of Success

➢ COMMON COGNITIVE ERRORS

We all have patterns of thinking, and this may impact our emotional state and behavior. Sometimes our patterns are less than accurate. These are cognitive errors or cognitive distortions, and they typically fall into certain categories. Learning to recognize our
own cognitive errors increases our ability to ignore the negative thought or actively change it, which enables us to intentionally change our emotions and our behaviors. The following is a list of the most common cognitive distortions:

1. **All-or-Nothing Thinking** Putting experiences in one of two categories
   Examples: 1) People are all good or all bad. 2) Projects are perfect or failures. 3) I am a sinner, or I am a saint.

2. **Over generalizing** Believing that something will always happen because it happened once
   Examples: 1) I will never be able to make friends at a party because I once made an awkward statement to someone, and they didn’t want to be my friend. 2) I will never be able to speak in public because I once had a panic attack before giving a speech.

3. **Discounting the Positive** Deciding that if a good thing happens, it must not be important or doesn’t count
   Examples: 1) I passed the exam this time, but it was a fluke. 2) I didn’t have a panic attack today, but it’s only because I was too busy to be worried.

4. **Jumping to Conclusions** Deciding how to respond to a situation without having all the information
   Examples: 1) the man/woman I am interested in never called me back because he thinks I’m stupid. 2) That person cut me off in traffic because he/she is a jerk!

5. **Mind Reading** Believing that you know how someone else is feeling or what they are thinking without any evidence
   Examples: 1) I know she hates my guts. 2) That person thinks I’m a loser.

6. **Fortune telling** Believing that you can predict a future outcome, while ignoring other alternatives
   Examples: 1) I’m going to fail this test. 2) I’m going to have a panic attack if I go out in public.
7. **Magnifying (Catastrophizing) or Minimizing** Distorting the importance of positive and negative events. Examples: 1) I said the wrong thing so I will never have a boyfriend/girlfriend. 2) My nose is so big that no one will ever love me. 3) It doesn’t matter if I’m smart because I will never be attractive, athletic, popular, rich, etc. 4) Making a mountain out of a molehill

8. **Emotional Reasoning** Believing something to be true because it feels true. Examples: 1) I am a failure because I feel like a failure. 2) I am worthless because I feel worthless.

9. **“Should-y” Thinking** Telling yourself you should, should not, or should have done something when it is more accurate to say that you would have preferred or wished you had or had not done something. Examples: 1) I should be perfect. 2) I should never make mistakes. 3) I should not be anxious. 4) I should have done something to help.

10. **Labeling (or Mis-Labeling)** Using a label to describe a behavior or error. Examples: 1) He’s a bad person (instead of “He made a mistake when he lied.”) 2) I’m stupid (instead of “I didn’t study for my test, and I failed it.”)

11. **Personalization** Taking blame for some negative event even though you were not responsible, you could not have known to do differently, there were extenuating circumstances, or other people were involved. Examples: 1) It’s my fault he hits me. 2) My mother is unhappy because of me.

**1.6.8 Cognitive Behavioural Therapy, Pharmacotherapy and Obsessive Compulsive Disorder**

The pharmacotherapy functions like water wings do in helping a child to learn to swim: It reduces the fear and makes it easier to “float along” while you’re learning the strokes. The analogy seems particularly apt because just as children who are learning to swim...
can function with less and less air in the water wings and eventually do without them, people with Obsessive Compulsive Disorder who use Cognitive Behaviour therapy can get by with lower and lower doses of pharmacotherapy as the weeks go by and they keep working on their behaviour therapy. Eventually many of them end up on low doses or no medication at all.

In the start the patient has increased anxiety level, less stabilisation to go through Cognitive Behaviour Therapy hence first with the help of pharmacotherapy the anxiety reduces and set the stage for Cognitive behaviour Therapy.

In Obsessive Compulsive Disorder, one of the effective treatments is Cognitive Behaviour Therapy and Pharmacotherapy supporting these treatments it was found in this research that requirement of pharmacotherapy is gradually reduced, it has good efficacy (good improvement) and was having perpetuating effects. Also with the help of this treatments patient is able to help himself for lifetime.