

OCD: An Analysis of Clinical Obsessive-Compulsive Disorder in Modern Society

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Obsessive-Compulsive Disorder, known as OCD in short, is a relatively recent psychological phenomena that has begun to demand an increasing amount of attention and focus from medical and psychiatric institutions due to higher rates of clinical diagnosis. While estimates of OCD sufferers range from less than 1% to more than 5% of the total population, symptoms of OCD are commonly found within a significant percentage of all individuals at one point or another of their lives.

This paper attempts to examine the current research that has been conducted of OCD and to examine released statistical data for any emerging patterns of diagnosis. This paper also attempts to clear up any current myths about OCD as portrayed by either the media or pop culture. The importance of research on OCD to our society is also mentioned within the paper, as well as potential root causes of the disorder. Finally, a prescriptive section dealing with possible effective treatment techniques and methods is detailed at the end of the paper.

Definition of the Problem

Obsessive-compulsive disorder (OCD) is defined by *Oxford Reference* as “An anxiety disorder characterized by either obsession or compulsions, recognized by the afflicted person (if an adolescent or adult) as excessive or unreasonable, causing significant distress, wasting significant amounts of time, or markedly interfering with everyday life, occupational or academic performance, or social interaction” (2005).

In terms of classification, obsessive-compulsive disorder is regarded by most psychologists as being a neurotic disorder, as opposed to a psychotic disorder. Neurotic disorders, such as panic disorder and generalized anxiety, are usually less debilitating than psychotic illnesses, such as schizophrenia. However, severe OCD symptoms are critically disabling, and can affect a person’s life in a drastically negative way (Jakes, 1996).

Three attributes emphasize obsessive-compulsive disorder as a neurotic disorder rather than a psychotic disorder. First, the patient has a self-realization of his or her problems and understands the awareness. This is in direct contrast to most psychotic disorders, where victims consistently deny or are unaware of their conditions. Second, most neurotic disorders are minor in degree, especially when compared to some psychotic disorders such as schizophrenia. Finally, the majority of people with OCD or OCD symptoms still have a functioning world – even though the degree at which it

is functioning is subject to the patient’s severity of the disorder. The common psychotic person, nonetheless, may have no functioning world and a total lack of communication with other people (Jakes, 1996). Specifically, obsessive-compulsive disorder is viewed as an anxiety disorder. Obsessive-compulsive disorder, however, is vastly different than most other anxiety disorders, such as phobias and panic illnesses, because of the diversity of the symptoms experienced. Nevertheless, these disorders all share the common base of anxiety, and there is still some commonality in terms of symptoms between the different anxiety disorders (Jakes, 1996). It is important to realize that in order for a person to truly develop a case of obsessive-compulsive disorder, it must “affect his everyday functioning or causes him distress” (Silva & Rachman, 1992, p.1). Occasional symptoms of OCD are prevalent in a large percentage of the population, yet those symptoms are no indication that a person has obsessive-compulsive disorder. Furthermore, the diagnosis of obsessive-compulsive disorder must be made by a professional - someone such as a psychiatrist who diagnosis the patient on a variety of criteria and psychological testing (Foa & Wilson, 1991).

In order to generate a clear picture of what obsessive-compulsive disorder actually is, one must realize that there are two components of the disorder. Obsessive-compulsive disorder can be broken down by the individual terms “obsessions” and “compulsions”.

Obsessions are defined, according to Silva & Rachman (1992), as “recurrent, persistent ideas,

thoughts, images, or impulses that intrude into consciousness and are experienced as senseless or repugnant” (p.2). It is important to note that obsessions are neither wanted nor consciously created by the victim – they are characterized as an unwelcome outsider. In addition, people realize that they have these obsessions and try to resist or dispose of them. Obsessions can occur to people at all times of conscious life. For example, they can occur during everyday activities such as exercising. Obsessions can range from a wide variety of topics – from notions of contamination and germs to violent acts, perverse sexuality, and religion (Jakes, 1996).

Compulsions, on the other hand, are “repetitive, purposeful forms of behavior that are carried out because of a strong feeling of compulsion to do so, and are usually performed according to certain rules or in a stereotyped fashion” (Silva & Rachman, 1992, p.2). The act of committing compulsions is not “an end in itself, but is usually intended to produce, or to prevent, some event or situation” (Silva & Rachman, 1992, p.2), however illogical or useless that event is.

Compulsions are usually realized by the person as being illogical or senseless, and the patients try to resist, but oftentimes to no avail. At other times, compulsions are committed in order to prevent harm to others. An example of is a person looking at a photograph of a relative a certain number of times a day so that they are not harmed. In addition, compulsions are also committed simply to dispel any anxiety or to satisfy any distress within the person themselves. Compulsions are accompanied by a strong urge to do so and the instinctive feeling that “it’s just right”. Since compulsions can be carried out on a day-by-day basis, they are also characterized by the term “ritual” (Rachman, 1976).

Together, the characteristics of obsessions and compulsions combine to form the basis of the obsessive-compulsive disorder. While patients *can* have only either obsessions or compulsions alone, they are far more likely to develop the disorders in tandem, as obsessions complement compulsions and vice versa. Furthermore, obsessions usually cause compulsions in the sense that obsessions provide the mental fuel for the physical act of compulsions (Rachman, 1976).

Finally, it is important to realize that there are four different kinds of obsessive-compulsive disorder. These subcategories include: washing/cleaning, checking, overt compulsions, and ruminations. Patients suffering from OCD may present

the symptoms of only one subcategory or several in conjunction.

Briefly, “Washers/Cleaners” are the most common type. These include people who are obsessed with the notion of cleanliness to such an extent as to deem most surfaces and objects to be contaminated with germs or dust or pollution. The compulsions, therefore, are to constantly clean these objects however many times a day it is necessary to keep them “clean” in the eyes of the patient (Steketee, Grayson, & Foa, 1985).

“Checkers” are usually people who are obsessed with security and order. These people will repeatedly check to make sure everything is in order. There are constant obsessive doubts as to whether the patient did everything correctly. For example, a person would be considered a “Checker” if they pulled on all four door handles of their car several times in a row to make sure that the car was locked (Steketee et al., 1985).

“Overt Compulsions” are compulsions that are not within the common groups of “checkers” and “washers/cleaners”. This can include a wide variety of instances, such as list-making or arranging/straightening things, or even doing everything in certain sets of a number – such as washing yourself five times day, eating five times a day, reading five times a day for five minutes each time, etc. (Jakes, 1996).

Finally, “ruminations” are mental obsessions that translate directly to mental compulsions. In other words, while no physical acts are committed, the person has to go through with mental compulsions such as ritualized thinking in order to satisfy their mental obsessions. For example, a person who is obsessed with the doubt that they swore that day would mentally try to go over everything they had said that day, just to make sure that they haven’t cursed (Jakes, 1996).

Importance of the Problem to Society

From the findings of recent surveys, clinicians, and a multitude of psychiatric services, it has been discovered lately that the amount of the general population affected by obsessive-compulsive disorder (not including occasional minor symptoms) is greater than previously thought. In the middle of last century, the 1950’s and 1960’s, OCD was a disorder thought to only affect a small sample of the population - below 1%. However, new data points to an estimate of much greater figures,

in the range of 1-3% (Silva & Rachman, 1992). Some estimates range even higher, as Neziroglu & Yaryura-Tobias (1991) write, "Obsessive-compulsive disorder appears to affect between 3 percent and 5 percent of the general population" (p. 185). The reason that the new figure is a range and is not simply one number is based on the findings of many different surveys conducted on individual cities in recent years.

For example, a 2000 self-survey sent to several random population samples within three different US cities showed major preponderance in the disparity of people affected. The three cities surveyed in the US were St. Louis, Baltimore, and New Haven, with respective percentages of 1.9%, 3.0%, and 2.6% (Silva & Rachman, 1992). These cities have a range of percentages affected – thus, no one conclusive figure can be stated to represent the diversity in statistical findings across the United States. The same range of OCD rates in the United States is most likely representative of the global population as well. Of course, self-surveys may very easily err in statistical accuracy, but the generally accepted notion is that OCD affects a far greater amount of the population than previously thought. On a side note, obsessive-compulsive disorder is now deemed more common than schizophrenia (Goodman et al., 2000).

Most psychologists and professionals dealing with OCD do not believe that there has simply been a growth of OCD among the population – that more and more people are developing obsessive-compulsive disorders these days than in the recent past. Professionals do believe, however, that past tests and surveys were inadequately conducted so as to underestimate the actual percentage of people affected in the United States (Jakes, 1996). In addition, recognizing the symptoms and diagnosing the actions of obsessive-compulsive sufferers is much easier nowadays because professionals have better notions of what exactly is OCD. In other words, the guidelines for defining the concepts of obsessive-compulsive disorder have been refined and clarified (Goodman et al., 2000).

Obsessive-compulsive disorder is not just a neurotic disorder that affects the United States. Clinical descriptions of people in many different cultures and countries show that patients exhibit the same symptoms and signs of OCD as in the United States, almost to an archetypical similarity. Silva & Rachman (1992) write, "The phenomena of obsessions and compulsions are not confined to one culture or one period of time. The basic features are

essentially the same across diverse cultural backgrounds and eras" (p.49)

In terms of gender, there is no indication that either sex has a greater preponderance of OCD than the other. However, it seems that obsessive-compulsive disorder develops earlier in males than in females. Nevertheless, there are subtle differences in gender within the subcategories of obsessive-compulsive disorder. For example, while males and females were approximately in equal proportion within both the "Checking" and "Overt Compulsion" subcategory, a generally higher figure of females are found in the "Washing/Cleaning" subcategory while a higher percentage of males are found in the "Ruminations" subcategory of obsessive-compulsive disorder (Silva & Rachman, 1992).

Age is also another very interesting factor in the frequency of people diagnosed with obsessive-compulsive disorder. Most cases of OCD are first developed in a patient during the years of late adolescence or early adulthood, with a large number of cases developing before the age of twenty-five. As Silva & Rachman (1992) note:

In one large series of patients seen in a London hospital, in 92 per cent of the cases the disorder began between the ages of 10 and 40...It is rare for someone to develop the disorder for the first time after the age of 45. By the age of 30, nearly three-quarters of all identified cases have been diagnosed. (p. 45)

There is also an indication in the demographics of patients with obsessive-compulsive disorder that most get married later in life when compared to both the average human being and other psychiatric patients. In the same sense that OCD patients are usually diagnosed before the age of twenty-five, they are usually unmarried, although there seems to be more unmarried males than unmarried females with obsessive-compulsive disorder. There is also a tendency for people with OCD to have fewer children when compared to the average person (Tukel, Ertekin, Batmaz, Alyanak, Sozen, Aslantas, Atli, & Ozyildirim, 2005).

An interesting note is that people diagnosed with obsessive-compulsive disorder seem to belong to higher social classes than the average person (Silva & Rachman, 1992). Furthermore, it is believed among professionals dealing with obsessive-compulsive disorder that patients suffering from the disorder have a higher educational level than the average individual, although there is a lack of concrete evidence and study on this matter (Neziroglu & Yaryura-Tobias, 1991).

Of course, the tendency exists that the more educated or wealthy a person is, the more likely they will seek either treatment or better understanding of obsessive-compulsive disorder. On the contrary, the less educated or poorer an individual is, the higher the chance that they will not have the knowledge or opportunity to pursue either treatment or better understanding of the disorder. Thus, it could be possible that there is a greater preponderance of better educated patients from higher social classes simply because more of these people are diagnosed with the disorder than poorer people with a lower educational background.

Obsessive-compulsive disorder widely ranges in terms of how it affects people. Certain patients are ever so slightly affected by the minute symptoms of OCD while in other cases obsessive-compulsive disorder in itself has become the way of life for patients with extreme severity. Nonetheless, obsessive-compulsive disorder has been said to be one of the ten most disabling mental conditions today (Foa & Wilson, 1991).

The effects of obsessive-compulsive disorder on the family of an affected patient can be widespread and severe. The nature of both obsessions and compulsions derived from the patient may spread to all of the family members, as the patients will involve family members with their obsessions and/or compulsions. While the family can be clearly stressed by this instance, it is also vital to note that a family is crucial in terms of providing support to a person coping with obsessive-compulsive disorder, especially if that patient is a child (Neziroglu & Yaryura-Tobias, 1991).

As noted before, many OCD patients will repeatedly seek reassurance for either their actions or their thoughts, or both. In the case of an obsession, an affected person may seek to ask whether they did something right or if they said something to a family member. That patient might keep asking those reassurance questions consistently, even though the family member has already confirmed the patient of reassurance the first time. This action may get tiring after a while, especially if the patient asks the same questions to the same people many times each day (Foa & Wilson, 1991).

In the case of a compulsion, the patient may ask, or rather, demand that the family members comply with their numerous actions. For instance, a compulsive "Cleaner/Washer" may have extremely strict rules on what the family members can touch or even walk on. It is not uncommon for these patients to tell their families that other members

cannot use certain features of the house, such as a bathroom or a shower. In addition, these patients may have absurd rules for entering or leaving a house, such as having to touch all four corners of a room when they enter any room in the house (Neziroglu & Yaryura-Tobias, 1991).

There are even more extreme cases, such as when a young woman married a man but would not let him into her house for fear of contamination. In another scenario, a woman refused to have sexual relations with her husband for fear of contracting germs. Quite understandably, a marriage with an obsessive-compulsive person yields a high divorce rate (Silva & Rachman, 1992).

In the workplace, the effects of obsessive-compulsive disorder are similarly felt. In fact, the most detrimental subcategory of obsessive-compulsive disorder to affect the workplace is the "Checker" type, since "Washers/Cleaners" have a habit of not leaving the home for fear of contamination. This is not to say that only the "Checkers" will be affected, for all affected OCD patients are affected by the disorder in their workplace. The "Checkers" are most affected simply because of their slow speed and repetitive behavior, which can become quite noticeable to most employers as their lack of efficacy increases (Steketee et al., 1985). In most cases, however, mild symptoms of OCD will not prevent the patient from functioning in the workplace, so to speak, but may well impair them in their hopes to accomplish everything they would like to accomplish in a certain amount of time (Silva & Rachman, 1992).

Time may also be a concern when dealing with the social aspect of people with obsessive-compulsive disorder. Since intricate mental obsessions and physical compulsions may take up an enormous amount of time, patients will not have the same amount of time to devote to social activities. Furthermore, friends might be deterred and confused by the activities that OCD patients employ to satisfy their compulsions, such as the lack of ability of some "Washer/Cleaner" types who refuse to shake hands for fear of contamination (Neziroglu & Yaryura-Tobias, 1991).

As one can see, the effects of obsessive-compulsive disorder have far-reaching effects into all aspects of a person's life, from work to home to social activities. Even more detrimental are the effects on the individual, who as noted before, actively realizes their unwanted obsessions and compulsions and struggles to resist them but often to no avail (Jakes, 1996). Thus, the effects of OCD transpire

between the individual and their lives, which can only mean that society is certainly affected by this disabling disorder which has shown to be far more common than previously recognized (Steketee et al., 1985).

Causes of the Problem

Clinicians and professionals dealing with obsessive-compulsive disorder note that there seem to be three major possible causes of the disorder: genetic, mental, and environmental. Genetic causes of the disorder include both relative genotypes and phenotypes while mental causes include both biological and psychological explanations. Environmental causes explore the events and stresses that can predispose a person to obsessive-compulsive disorder (De Araugo, Ito, & Marks, 1996).

Although there have been numerous studies on the causes of OCD, few are truly encompassing and conclusive. In addition, the prevalence of interest in obsessive-compulsive disorder has only escalated recently, in the second half of the twentieth century. Thus, the following explorations into the different possible causes of the disorder are merely insights and speculations based on thin amounts of evidence at best (Neziroglu & Yaryura-Tobias).

It is likely, however, that no one explanation or cause of OCD exists, but rather, a combination or assortment of causes contributes to the manifestation of the disorder. It is also important to note that some of the data collected from patients by clinicians is “retrospective” in nature, meaning that there is a strong possibility of error or inaccuracy as the patient tries to recollect past thoughts and actions (Jakes, 1996).

The first possible explanation for the development of obsessive-compulsive disorder involves the genetic component. Recently, there has been an explosion of interest into this pathological aspect of obsessive-compulsive disorder. Both a relative’s genotype and phenotype are investigated as plausible causes of the disorder. While phenotype testing is less concrete and harder to measure than genotype results, both have grabbed the attention of scientists and OCD theorists who believe that the origins of the problem can be found on the human genome (Jakes, 1996).

The question of whether or not obsessive-compulsive disorder is passed through by heredity begs to be answered by studies that are not currently sufficient. There are, however, recent studies of

identifying obsessive-compulsive disorder in twins of both monozygotic (identical) and dizygotic (non-identical) nature and comparing the ensuing data, such as a study by Silva & Rachman (1992) conducted in the early 1970s. While the results were mixed and the studies inconclusive, it seems that there may be a slightly higher rate of “concordance” for the identical twins. In other words, there are more cases of both twins having the disorder in monozygotic twins than in dizygotic twins (Silva & Rachman, 1992).

A similar study performed by Silva & Rachman (1992) in London compared the state of first degree relatives (i.e. children, siblings, parents) of fifty OCD patients with a group of first degree relatives from non-OCD patients. The data shows that there is a greater preponderance of psychiatric disorders in general from the relatives of OCD patients over the relatives of the non-OCD patients, yet there was no correlation between obsessive-compulsive disorders between either of the two groups (Silva & Rachman, 1992).

Although most studies suggest a slight genetic contribution of obsessive-compulsive disorder among relatives, further testing and studies need to be committed in order to draw a justifiable conclusion. The available studies do seem to imply, however, that obsessive-compulsive patients genetically contribute a predisposition to the development of some form of an anxiety disorder in their offspring in the form of “general emotional oversensitivity, or a neurotic tendency” (Silva & Rachman, 1992, p.48).

On the topic of obsessive-compulsive disorder heredity, one might also wonder as to whether the parent phenotypes affect the offspring. If one or both of the parents of a given household have obsessive-compulsive disorder, will that incline the children to have OCD as well? Silva & Rachman (1992) write, “Many children briefly display comparable behaviour, but very few indeed ever develop obsessive-compulsive disorder...If anything, they are more likely to develop overdependence and timidity” (p. 47).

The second possible causation of obsessive-compulsive disorder involves the mental aspect of the human brain, both psychologically and biologically. Biologically, a new theory proposes that a brain imbalance is the root of the disorder. Psychologically, two views – the Psychoanalytic view and the Learning Theory – both try to explain the origins of obsessive-compulsive disorder.

Several professionals in the field of OCD have

proposed that the disorder is caused by a 'biological disturbance'. Biologically speaking, the brain chemistry of people with obsessive-compulsive disorder differs from that of a normal human being. Specifically, experts claim that the disorder is due to a lack of a particular chemical substance named serotonin. Serotonin plays an essential role in the functioning of brain processes, as it acts a neurotransmitter between brain cells (Schilder, 1938).

The biological theory was originally derived from successful trials of treating OCD in people by prescribing to them an antidepressant named clomipramine, which blocks the loss of serotonin from the brain (Pato et al., 1991). However, clinical trials have shown that obsessive-compulsive disorder can be successfully treated in patients simply by psychological methods – altogether ignoring brain chemistry and the levels of serotonin (Goodman et al., 2000).

In addition, there is no conclusive evidence as to the difference in serotonin levels between sufferers of other anxiety disorders and obsessive-compulsive disorder. High dosages of clomipramine – and thus higher amounts of serotonin – do not guarantee freedom from OCD symptoms. In addition, it is imperative to note that the initial response of a patient suffering from OCD to clomipramine is non-predictive of the long term effects of the drug, which have not been carefully studied yet (Zohar, Insel, Kadouch, Hill, & Murphy, 1988). Finally, one should realize that while clomipramine may help some cases of people with OCD, it does not mean that a lack of clomipramine or serotonin is the cause of the disorder, in the same sense that even though aspirin alleviates headaches, a lack of aspirin does not cause headaches in the first place (Goodman et al. 2000).

Turning now towards the psychological half of the mental aspect, the Psychoanalytic view is based on the rationale of the psyche first significantly developed by the late Sigmund Freud. It is important to note that this view is a purely theoretical approach towards explaining OCD; it has neither been adequately implicated nor applied for treatment, and thus no studies exist to verify the theory's authenticity. On a further note, the testing of this theory would be extremely difficult to perform, as one would have to have complete records of an individual's thoughts and actions throughout their lives (Silva & Rachman, 1992).

Without going into depth about Freud's theories, the Psychoanalytic explanation of obsessive-compulsive disorder involves problems buried deep

within a patient's unconscious mind. The view takes the approach that certain anxiety-causing memories/thoughts are kept out of the conscious mind until they later present themselves in forms of neurotic disorders. Different kinds of stimuli during the developing stages of life, in the forms of frustrations, conflicts, impulses, and desires, may later contribute to the onset of OCD in a patient's late adolescence. Specifically, the Psychoanalytic theory proposes that negative stimuli experienced during the "Anal-Sadistic Stage", or rather the toilet training stage of one's developing years is key to the later manifestation of obsessive-compulsive disorder in people. Again, this theory is purely theoretical in nature and is very difficult, if not impossible, to test (Silva & Rachman, 1992).

Environmental causes of obsessive-compulsive disorder serve to explain the development of OCD by events and stresses a person is exposed to during their lifetime. The Learning Theory is an attempt to explain the origins of obsessive-compulsive disorder through the notion of anxiety relief. In short, the theory assumes that OCD is acquired by way of learning and habituation within the patient. From past trauma and/or unwanted experiences, an individual may begin to "learn" or associate relatively harmless stimuli with anxiety (De Araugo et al., 1996). For instance, a person may become anxious about touching cars after being involved in a major car accident. The individual may then begin to relieve this anxiety through various channels of certain behaviors, such as rituals or compulsive behaviors, which could then lead to mental obsessions. Over time, those acts of anxiety relief become permanent fixtures in the person's life, thus predisposing the person to the onset of obsessive-compulsive disorder (Jakes, 1996).

Although the Learning Theory is relatively new, it has been tested numerous times in several different studies. In many diverse animal studies of the same concept, animals were placed in new situations that were either painful or totally alien to them. Most of the animals began to commit acts that, although useless to alleviate their current situation, were reminiscent of past experiences which reduced anxiety. To draw on an animal's anxiety as being similar to that of a human's, Jakes (1996) writes, "...Gray is right in asserting that the brain mechanisms that subsume the experience of anxiety in human beings and animals are largely the same..." (p. 56). One could argue that there is a significant difference between the psyche of an animal and that of a human, but the phenomenon

observed is valid in almost all animal groups and serves to merely lend a hand in suggesting a similarity between animal and human behavior (Jakes, 1996).

There are three aspects of obsessive-compulsive disorder that the Learning Theory fails to accommodate. First, there are patients with OCD who do not remember any traumatic events which would have caused them to harbor anxieties in the first place. Thus, there seems to be no basis for some of any unwanted experiences that could have initiated the sequence towards developing obsessive-compulsive disorder (Silva & Rachman, 1992).

Second, the Learning Theory does not cater to the observation that certain obsessions and compulsions are so common while others are not. For example, why are so many people “Washers/Cleaners”? What common traumatic events could have shaped all of these people to be similar in their OCD (De Araugo et al., 1996)?

Finally, the Learning Theory does not answer questions of why certain obsessions and compulsions develop about meaningless thoughts regarding numbers, orders, patterns or symmetries. What possible painful experience with these intangible categories could a person have gone through to base their obsessions and compulsions on those anxieties? It is crucial to remember that while the Learning Theory satisfies most cases of obsessive-compulsive disorder, it does not explain the entirety of the disorder (Goodman et al., 2000).

Effective Strategies that Address the Problem

While some psychological disorders and medical conditions have been recognized for several centuries now and treatments for them have been fully and completely developed, obsessive-compulsive disorder has only grabbed the attention of the psychological world relatively recently. Untreated figures seen in past history as having acute symptoms of obsessive-compulsive disorder range from as recent as millionaire Howard Hughes in the early 1900s to as ancient as Buddhist monks before the birth of Christ. Yet successful treatment of OCD did not arguably develop until the latter part of the 20th century. Silva & Rachman (1992) write, “Most obsessive-compulsive patients can now be successfully treated, in contrast to the situation even as recently as the 1960s, when there was almost a resigned acceptance that little could be done to help

them” (p. 56).

There are two commonly recognized forms of treatment available to patients with varying degrees of the disorder. Treatment ranges from psychological therapy to drug use. The order of treatments available to OCD patients just mentioned is also representative of the popularity and frequency of usage among patients from most common to least common, respectively (Goodman et al., 2000).

Although there are some other, radically divergent treatment options such as electroconvulsive therapy¹ (ECT) and psychosurgery², they are rarely performed and the evidence and supporting data on their success rates is almost nonexistent (Neziroglu & Yaryura-Tobias, 1991). Thus, neither ECT nor psychosurgery will be discussed in the following section. Combining multiple forms of treatment such as pairing psychotherapy with drug treatment is a relatively new concept to OCD clinicians, so there is a severe lack of evidence as to the effectiveness of that procedure. However, there have been some patient cases which demonstrate that combination treatments *can* potentially be successfully. In that regard, only the passing of time and the volume of future trials will tell how successful combination treatments are (Goodman et al., 2000).

It is vital to remember that due to aspects of medical and psychological confidentiality agreements, most cases of patient treatment and the documentation of their treatment successes and failures are not disclosed to the public. In addition, ethics and morals limit professionals and clinicians as to how far they can go to test the success of a certain treatment. For instance, it would be highly unethical to conduct experimentation of drug therapy to patients with varying degrees of OCD, some of whom might not need that particular treatment at all in the first place (Neziroglu & Yaryura-Tobias, 1991).

Thus, while treatment for obsessive-compulsive disorder has become readily available with a generally good rate of success, it is not always possible to examine each and every case. The available research of current treatments is based off of disclosed cases that are open to view by both the general public and OCD theorists (Silva &

1 Also called “shock” therapy, ECT is performed with electrical current passing through electrodes placed on the head while the patient is under a short-term general anesthetic and a muscle relaxant.

2 In essence, invasive neurosurgery in which a small section of the frontal lobe is removed from the brain.

Rachman, 1992).

In mentioning the psychological aspects of treatment for obsessive-compulsive disorder, one needs to realize that there are three main subcategories of psychological treatment. They are, in order of respective popularity from most frequent to least performed, Psychotherapy, Hypnotherapy, and Group therapy. The common drawback for these forms of treatment is a possibility of relapse, as these forms of therapy are not meant to be continued indefinitely (Neziroglu & Yaryura-Tobias, 1991).

Psychotherapy is a form of psychological treatment derived originally from Freud's studies of the human psyche. Psychotherapy aims at treating not the surface symptoms of obsessive-compulsive disorder, but rather, the underlying problems buried deep within the unconscious. The goal of psychotherapy is to treat the patient's underlying problems by "talking them out" between the therapist and the patient. The relationship between a patient and a therapist is crucial to the success of the treatment (Foa & Wilson, 1991).

Psychotherapy may go on for an extended period of time until all of the underlying problems are thought to have been dealt with and the surface symptoms of OCD gone. It is not unusual that patients see a therapist several times a week for a couple of years. In addition, psychotherapy often gives the patient a new understanding of his life and provides him with an in-depth perspective on his personal problems (Foa & Wilson, 1991).

The main drawback of psychotherapy, along with the other psychological treatments, is that there is inadequate research and study to show the effectiveness of this form of treatment. In addition, psychotherapy is a private endeavor, and ends up usually being very expensive considering the duration of most psychotherapy treatments. It is also to be noted that the patient may experience some initial "distress" at having to adapt to new methods for satisfying their anxieties. The patient is also expected to be highly self-motivated. Otherwise, they may resort to their old obsessions and compulsions during the course of therapy (Silva & Rachman, 1992).

During the initial stages of treatment, a patient may also experience depression in conjunction with their "distress" of changing their lifestyles and thought processes. This usually cures itself in the following weeks of treatment and the patient begins to successfully cope with their new habits. Drug intervention for the initial depression felt by a patient is not recommended, as anti-depressants

may add a side effect to the therapy (Foa & Wilson, 1991). Finally, another drawback of psychotherapy is that there is no indication of exactly when a patient will be "free" from their symptoms of the disorder. The process of letting go is a tender transition, and must be carefully decided upon by both the therapist and the patient on a case-by-case basis (Silva & Rachman, 1992).

Hypnotherapy is a relatively new method for dealing with OCD. Although not proven effective by any means, many people have reported partial successes in dealing with their obsessive-compulsive disorder through hypnotherapy (Goodman et al., 2000). Usually, the hypnotist will make strong statements that refute the obsessions or compulsions of a patient while they are under hypnosis. For instance, the hypnotist might tell a hypnotized "Cleaner/Washer" that they have nothing to fear from germs and contamination, and that they will not continue to clean or wash excessively. There have been no concrete studies as to the effectiveness of this method of treatment (Neziroglu & Yaryura-Tobias, 1991).

Group therapy, although proven very useful in various eating disorders and addictions, has not been extensively studied in the treatment of obsessive-compulsive disorder. Usually, patients exhibiting similar signs of OCD or patients that are the same type of OCD (i.e. "Washer/Cleaner" or "Checker") are grouped together to provide support systems for each other. Social interaction within the group will allow the members to help each other learn about the disorder as it affects them individually (Silva & Rachman, 1992). Group therapy has been found to be an additional help for patients who are already receiving treatment via individual therapy. In addition, family members can also join the group and act as additional pillars of support for the patient. However, there is no substantial evidence that group therapy is an effective method for treating obsessive-compulsive disorder, either by itself or stacked with another form of treatment (Neziroglu & Yaryura-Tobias, 1991).

Drug use, on the other hand, is a form of pharmacological treatment that many professionals and clinicians believe to be highly effective in the case of treating obsessive-compulsive disorder. As mentioned in the biological pathologies section above, there is a reported chemical imbalance in the brain of OCD patients. Specifically, there is a lack of serotonin (Schilder, 1938). In addition to the aforementioned clomipramine, clinicians have documented that a wide range of antidepressants

Common Antidepressant Drugs Used to Treat Obsessive-Compulsive Disorder

Drug	United States Brand Name	Recommended Dosages
<i>Tricyclics</i>		
Clomipramine	Anafranil	Approx. 150-250 mg/day
Amitriptyline	Elavil/Amitrid /Endep	Varies
Imipramine	Tofranil/SK-pramine /	Varies
<i>Monoamine Oxidase Inhibitors</i>		
Phenelzine	Nardil	Varies
Tranlycypromine	Parnate	Varies
Isocarboxazid	Marplan	Varies
<i>Others</i>		
Fluoxetine	Prozac	Approx. 20-80 mg/day
Fluvoxamine	Faverin	Approx. 150-300 mg/day

Note: From *Obsessive-Compulsive Disorder: The Facts* (p. 107), by P. D. Silva and S. Rachman, 1992, New York, NY: Oxford University Press. Copyright 1992 by Oxford University Press. This list may now be incomplete and recent changes or revisions may have taken place.

are effective in the treatment of obsessive-compulsive disorder because of their ability to counteract the loss of serotonin within the patient's brain (Goodman et al., 2000). Also, Neziroglu & Yaryura-Tobias (1991) write:

Obsessive-compulsive disorder has been considered a form of anxiety or depression, because both anxiety and depression are very common findings in OCD. That explains the extensive use of anti-anxiety and antidepressant drugs for OCD. (p. 104)

A table of information about common antidepressants used to treat OCD has been compiled and is shown above.

In a massive study conducted in London in 1970 by the British Medical Research Council, the effectiveness of the tricyclic drug clomipramine was observed in numerous cases. It was reported that clomipramine was effective in reducing both depression and the rate of obsessions and compulsions in patients that were suffering from both. On the other hand, clomipramine had very little effect on patients who were affected by OCD alone (Silva & Rachman, 1992). More recent studies point to inconsistencies in the performance of clomipramine in treating obsessive-compulsive disorder (Pato, Zohar-Kadouch, Zohar, & Murphy, 1991). The conclusion of the Medical Research Council was as follows:

On balance, the evidence points to the conclusion that clomipramine is effective, especially when depression is also present; but the improvements are seldom complete, and a significant minority of patients do not benefit from the drug. (Silva & Rachman, 1992, p.77)

In addition to the drawbacks of serotonin-loss

inhibitors such as the antidepressant clomipramine mentioned in the previous section, side-effects from antidepressants in general include the following: nausea, drowsiness, sexual dysfunction, dizziness, dryness of the mouth, and finally, constipation. Antidepressants may also take several weeks to begin their effects on the patient (Zohar et al., 1988). In general, antidepressants are also known to become habit-forming, and patients who absolutely need the drug for long stretches of pharmacological treatment are recommended that they cycle the drug in periods of six to eight weeks at a time. Finally, as mentioned before, there is always a possibility of relapse once the patient decides to discontinue taking the prescribed medications (Pato et al., 1991).

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