

# Obsessive Compulsive Disorder (OCD)

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## *Description of the Disability*

OCD is an anxiety disorder that involves recurring obsessions or compulsions that are severe enough to be time consuming (usually an hour or more a day) or to cause distress or significant impairment. The obsessions and compulsions interfere with the person's normal routine, occupational functioning, usual social activities, and relationships with friends and family.

- An **obsession**, according to the DSM IV, is a recurrent and intrusive thought, feeling, idea, or sensation. They may be accompanied by unpleasant feelings like fear, disgust, repulsion, or a strong need to have things "just so".
- A **compulsion** is a conscious, standardized, recurring pattern of behavior, such as counting things, checking on safety, or avoiding something. Unlike compulsive gambling and related problems, these compulsions do not bring pleasure.

In some ways, compulsive behaviors are often quite adaptive for the person. A person with OCD may be using compulsive behaviors as a tool to keep obsessive thoughts at bay. While the person is carrying out the compulsive behaviors, the obsessive thoughts decrease. "Giving in" to the obsessive thoughts (by running them through one's head repeatedly) can increase the person's anxiety. In contrast, compulsions work in reverse - carrying out compulsions can reduce anxiety, while resisting the compulsion increases anxiety. So "giving in" to compulsive behaviors has a double benefit - the person gets relief from the anxiety of resisting the compulsion and from the intrusive thoughts of an obsession.

People with this disorder often know that their thoughts or behaviors are irrational, but they are unable to stop themselves. This level of self-awareness distinguishes people with OCD from people with conditions involving delusions or eccentric beliefs. Individuals with the disorder sometimes describe it as having mental hiccups that won't go away.

In general, OCD has four major patterns of symptoms, but each individual is different. Some people may have a mixture of these patterns, others only one. The patterns are:

- Contamination. This is the most common pattern and usually shows up as excessive washing or the compulsive avoidance of things perceived to be dirty.
- Pathological Doubt. This is the second most common pattern is an obsession of doubt and it usually leads to a compulsion of checking. Checking involves behaviors such as multiple trips back into the house to check the stove, locks, etc. Generally the doubt is focused on a fear of causing harm to themselves or friends and family.
- Intrusive Thoughts. In the third most common pattern, there are intrusive, obsessional thoughts without a compulsion - for example repetitious thoughts of a sexual or aggressive act that are bothersome to the person. This pattern is sometimes called Purely Obsessive, or "pure O."

- Symmetry. The fourth most common pattern is the need for symmetry or precision, which can lead to a compulsion of slowness. The person with a symmetry compulsion may take hours to eat a meal or shave their face because everything has to be done symmetrically.
- Other patterns can include religious obsessions (including compulsive praying); moral doubt; compulsive hoarding, list making, counting, or touching; mentally repeating phrases; and a compulsion to tell, ask, or confess.

Researchers think a neurological problem in the brain causes OCD rather than it being caused by life events such as family problems or childhood trauma. Symptoms may wax and wane over years, but the disorder is chronic and, untreated, will last for years or decades. Some individuals have regimented, static rituals they stick to while others have rituals that change with time.

Although most people with OCD are aware that they have a problem, they can show a range of the degree of awareness. Sometimes, especially when they are not currently experiencing an obsession, they are very aware that their obsessions, compulsions, and fears are unreal and create problems. At other times they may not be clear on that issue and may believe very strongly that, for instance, the compulsions are the only way to protect themselves and their family or friends from harm. Or they may know their compulsions and fears are irrational even as they perform the behaviors but are unable to stop.

Some individuals learn on their own to restrict the OCD behavior to private settings or to the evening. By containing the compulsions, they can reduce the symptoms during the day or in public, reducing personal embarrassment. However, the compulsions will usually continue to use up an enormous amount of personal time and reduce the time available for other activities of daily living.

OCD is distinct from OCPD - Obsessive Compulsive Personality Disorder, which paradoxically does not involve obsessions or compulsions. Instead, OCPD is a personality disorder involving a fixation on time schedules and rules, excessive devotion to work, perfectionism, and overall inflexible attitudes. OCD and OCPD can sometimes be coexisting conditions and they may respond to similar treatment. For more, see the OCPD description in the Personality Disorders Entry.

There are several other disorders involving impulse control and anxiety that are similar to OCD but do not quite fall within its official definition. Some researchers call these **OC Spectrum Disorders**. The OC Spectrum Disorders include:

- Body Dysmorphic Disorder - an obsessive preoccupation with a defect in your appearance.
- Olfactory Reference Disorder - an obsessive, irrational fear that your body stinks.
- Hair Pulling (Trichotillomania) - a compulsion to pull out your own hair, causing noticeable hair loss.

- Compulsive Skin Pricking (CSP) - a compulsion to prick your own skin, causing physical damage.

These spectrum disorders often have similar functional consequences as OCD and respond to similar treatments and accommodations.

### ***Incidence Statistics***

- The condition is usually misdiagnosed initially and individuals usually seek help for several years before getting a correct diagnosis.
- 2-3% of the population will acquire OCD at some time in their life.
- The average age of onset is 20 years, but up to one third of cases may have started in childhood or adolescence.
- It rarely occurs after age 40.
- The disorder occurs in equal numbers of men and women.
- 67% of people with OCD have depression.
- 25% of people with OCD have social phobias.
- SSRI drugs reduce symptoms by at least 25%-35% in about 75% of individuals with OCD

Other coexisting disorders can include depression, eating disorders, ADHD, substance abuse, other anxiety disorders, and tic disorders such as Tourettes. These coexisting disorders can often make OCD difficult to diagnose initially.

### ***Common Treatments, Medications, and Side Effects***

Treatment for OCD is usually focused on drug therapy and cognitive-behavioral therapy, alone or in combination. Many of the antidepressants, specifically the SSRI's (Selective Serotonin Reuptake Inhibitors), are being used for OCD, but in higher doses than for depression, (see Drug entry for more information on SSRI's). The most common SSRI's used in treating OCD are fluoxetine, fluvoxamine, paroxetine, citalopram, and sertraline. In the past, Clomipramine was commonly used - a tricyclic antidepressant with significant side effects. Anti-anxiety medications (anxiolytics such as Klonopin and Xanax) may be used for short-term treatment of severe anxiety symptoms. See Drug entries for possible side effects.

Exposure And Response Therapy is also an effective part of treatment. In this therapy, the individual is exposed to their triggering stimulus for the compulsions and then taught techniques to resist the response. See the entry on Anxiety Disorders for more detail on types of exposure therapy.

#### Psychosurgery

Drug therapy and counseling are usually very effective in treating OCD. On rare occasions, when those approaches fail, physicians try to treat OCD with "psychosurgery" (a type of neurosurgery) to modify/damage (but not completely cut) nerves in parts of the limbic system of the brain.

There are several different names for the surgery, depending on which part of the limbic system the surgeon targets. Physicians only resort to this very serious surgery when a person has a significant mood disorder, OCD, or other anxiety disorder that has not responded to any other, more conventional treatments. Only a few hospitals in the US, Canada, and Europe attempt the surgeries and the results vary widely. Studies report “satisfactory” results for between 25% and 70% of individuals getting the procedures. The procedures seem to work best for reducing OCD symptoms, and are less successful for other anxiety or mood disorders.

### ***Possible Functional Issues***

- Perseveration - staying on the same task for long periods of time
- Social difficulties
- Depression
- Fatigue from poor sleep
- Rituals or habits that are distracting to others
- Strong on detail-oriented tasks

### ***Initial Interview Considerations***

#### Initial Questions

- What situations cause them the most difficulty?
- What accommodations have they found that help in those situations?
- What triggers, if any, have they found for their OCD symptoms?
- How well are they able to drive? (Some obsessive thoughts are triggered by driving)
- How well are they able to focus on a task for long periods of time?
- What side effects, if any, do they experience from their medication? Do they ever experience dizziness or nausea from the medication?
- How well are they able to keep to schedules? When they are late for a meeting, how many minutes late would they usually be? (Some individuals may be obsessed with time and consider even 4 or 5 minutes very late, others may find the compulsions delay them by hours)
- How well are they able to complete tasks on time? (Individuals obsessed with perfection may have trouble declaring a job finished. Others may have trouble meeting deadlines because of time spent on compulsions.)
- How well do they work with detail tasks?
- How, if at all, do they try to hide their symptoms from others?
- How do they feel about meeting the public? Would they feel anxious working in a job where they had to meet a lot of strangers?

- What is a typical day like for them? Are there times of day when their symptoms are better or worse?
- What is a typical weekend like for them?
- What church groups or social groups do they belong to? (gets at other interests, possible accommodations)

### Initial Observations

- How distracting, if at all, are their compulsions during conversation?
- How distracted, if at all, does the person appear during the conversation?
- Do they have any trouble understanding "big picture" issues - long term planning, long-term goals?
- Were they on time to the interview? If not, ask why. This may indicate a problem with keeping to a schedule.

### ***Possible Accommodations and Assistive Technology***

- Flexible deadlines, if keeping to schedules is a problem.
- Advanced warning of deadlines. Sudden deadlines ("I need this in two hours") are very difficult for people with OCD. It is better if they know several days in advance.
- In the case of "checking compulsions", enlist a cooperative neighbor who could be phoned to check their home as an alternative to going home. Similarly, a cooperative co-worker could double check things for them at work.
- Written instructions that the person can check as needed, especially for complicated or multi-step tasks.
- In the case of a cleanliness compulsion, provide them with their own set of tools in the work place that others do not use or touch. They may want to carry the tools with them at all times to assure "cleanliness."
- Provide a personal workspace that they control and others will not disturb. This will help with obsessions of contamination, checking, or symmetry.
- Provide a private area they can go to carry out compulsions if necessary.
- Flexible schedule to accommodate doctor's visits and therapy sessions.

### ***Career Planning Issues***

- Cognitive skills are generally not affected. Learning and problem solving skills should be unaffected if not intruded upon by obsessive thoughts.
- Manual dexterity and physical strength should not be affected.
- The person may have good attention to detail and detail-oriented tasks
- Jobs with consistent routines and tasks may be more appropriate

### ***Emerging Issues***

- Public Awareness
- Underlying causes of OCD

### ***Additional Information Resources***

- Obsessive Compulsive Foundation - [www.ocfoundation.org](http://www.ocfoundation.org)
- The Anxiety Disorders Association of America - [www.adaa.org](http://www.adaa.org)
- National Institute of Mental Health, OCD page:  
[www.nimh.nih.gov/anxiety/anxiety/ocd/index.htm](http://www.nimh.nih.gov/anxiety/anxiety/ocd/index.htm)
- OCD Resource Center of South Florida - [www.ocdhope.com](http://www.ocdhope.com)
- Mental Health Infosource (Part of Continuing Medical Education, an online continuing education provider for healthcare professionals) - [www.mhsource.com](http://www.mhsource.com)