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Obsessive compulsive disorder

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Abstract

Obsessive Compulsive Disorders have the potential to destroy people's lives. The negative consequences of Obsessive Compulsive Disorder can affect so many people-the people suffering from the disorder, the family of the sufferer, as well as the lack of insight of the disorder within the community. According to the Obsessive Compulsive Foundation (2010), the disorder affects between 2 to 3 million adults in the United States and around 500,000 children and teens have Obsessive Compulsive Disorder. Due to the alarming statistics and the secret lives of incredible pain and humiliation OCD sufferers' experience, it is imperative that mental health counselors educate their clients and families by knowing the facts. The purpose of this paper is to concentrate on the various types of obsessions and compulsions, the most effective therapies and treatments, as well as help for families and loved ones.

OBSESSIVE COMPULSIVE DISORDER

A Research paper
Submitted
in Partial Fulfillment
of the Requirements for the Degree
Masters of Arts

Angela Bigelow

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ABSTRACT

Obsessive Compulsive Disorders have the potential to destroy people's lives. The negative consequences of Obsessive Compulsive Disorder can affect so many people-the people suffering from the disorder, the family of the sufferer, as well as the lack of insight of the disorder within the community. According to the Obsessive Compulsive Foundation (2010), the disorder affects between 2 to 3 million adults in the United States and around 500,000 children and teens have Obsessive Compulsive Disorder. Due to the alarming statistics and the secret lives of incredible pain and humiliation OCD sufferers' experience, it is imperative that mental health counselors educate their clients and families by knowing the facts. The purpose of this paper is to concentrate on the various types of obsessions and compulsions, the most effective therapies and treatments, as well as help for families and loved ones.

Until recently, Obsessive-compulsive disorder was thought to be a difficult and rare disorder, but the World Health Organization has listed it among the top ten causes of disability worldwide (Feusner, 2005). The total cost of the disorder in the United States is approximately over 8 billion (Feusner, 2005). OCD can start at any age from preschool to adulthood. Although OCD does occur at earlier ages, there are generally two age ranges when OCD first appears. The first range is between ages of 10-12 and the second between the late teens and early adulthood (OCD Foundation, 2010).

There are more people than we know who have suffered in silence for fear of being judged “crazy”. It can take many years before a person with OCD to seek treatment due to the stigma of the disorder. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable (OCD Foundation, 2010).

Definition

Obsessive-compulsive disorder is characterized by recurrent thoughts, images, feelings, or behaviors that persist against the person’s wishes. It is usually accompanied by severe anxiety and marked impairment of functioning (Feusner, 2005). The Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV, 2000) recognizes Obsessive-compulsive disorder as an anxiety disorder and defines it as follows:

Obsessions:

- 1.) Recurrent and persistent thoughts, impulses or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress.
- 2.) The thoughts, impulses, or images are not simply excessive worries

about real-life problems.

3.) The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.

4.) The person recognizes that the obsessive thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion).

Compulsions:

1.) Repetitive behaviors (e.g. hand washing, ordering, checking) or mental acts (e.g. praying, counting, repeating words silently) that the person 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 distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.

The DSM-4 also requires:

1.) The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour per day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities.

2.) At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or not unreasonable. Note: This does not apply to children.

Symptoms

Obsessions and compulsions go hand and hand. There are four qualities that set clinic obsessions apart from preoccupation, temptation, and worries of everyday life: The qualities are intrusiveness, recurrence, unwanted, and inappropriateness (Osborn, 1998). A person with obsessive-compulsive disorder, in order to get rid of the unwanted thoughts, performs some act, which are the compulsions. Obsessions, in turn, make compulsions worse (Osborn, 1998). Compulsions usually have rules that go along with them, such as counting something a certain number of times. This type of

compulsion is said to be mental compulsions because of the thought rituals. Other common types of mental compulsions are repeating prayers and endless questioning. Observable compulsions are behavior compulsions, for example, washers and cleaners are examples of behavior compulsions. When an individual has compulsions of washing and cleaning, he or she may fear and worry about contamination of dirt, germs, or foreign substances. They ease their obsessive fears by washing their hands, showering, or cleaning their environment. Washing and cleaning relieves the distress temporarily, but the fears come back. With time, more washing and cleaning is needed to bring relief. They may avoid shaking hands with someone, or avoid public restrooms in fear of contamination (Osborn, 1998).

There are many different compulsions, for example, checking, ordering, and hoarding which are more common. Some people may have a mixture of the compulsions that could be hard to detect.

Interventions

People who are obsessive compulsive realize their behavior is irrational, but just exercising willpower is not effective. A combination of therapy, medication, and support groups seem to be the best interventions and have the best results.

A type of behavioral therapy, “exposure and response prevention” is usually the treatment of choice with patients affected by Obsessive-compulsive disorder. Patients are asked to list their obsessions and rank them in order according to severity of the anxiety experienced. The therapist exposes the patient to an obsession that causes the lowest anxiety. Exposure to this obsession is continued until the anxiety diminishes. After

this is successfully done, the therapist will move up to the next level of anxiety, and do the same procedure (Zepf, 2004). This therapy allows the patient to confront the feared object or idea, and then practice stopping the ritualistic behavior (Gard, 2004).

Another type of behavioral therapy is cognitive behavior therapy. Cognitive behavioral therapy is used to partly understand how the three components of emotions, behaviors, and thoughts interrelate (Valente, 2002). It involves recognizing distorted thinking and replacing it with more realistic ideas (Valente, 2002). The therapist helps the client learn to test by checking his or her obsessions against reality. This helps the client understand how the disorder affects him or her and to confront the discrepancy in his or her own mind. While as many as, 25% of patients refuse cognitive behavior therapy; those who complete it report a 50-80% reduction in symptoms after 12-20 sessions (Rachman, 2003).

Medication

Selective serotonin reuptake inhibitors generally are used first. These medications increase serotonin, a chemical messenger in the brain (Zepf, 2004). The patient maybe prescribed a combination of anti-anxiety medication, anti-depressants, and anti-psychotics (OCD Foundation, 2010). The dosage used tends to be higher than the dosage used to treat depression. These medications may take up to 12 weeks to feel the full effect. When patients are how well they are doing, they report moderate improvement after 8-10 weeks on medication. Approximately 40% to 60% of patients treated with serotonin reuptake inhibitors alone will have some relief (Valente, 2002).

Support Group

A good support group can be helpful for people with Obsessive-compulsive disorder and their family members. It provides education and treatment options. Support groups can potentially be a useful part of treatment. These groups provide a forum for mutual acceptance, understanding, and setting of goals (Corey & Corey, 2005). People new to the disorder can talk to others who have learned successful strategies for coping with the illness. A few years ago, there was only one support group for the disorder. Today, there are several groups including one for parents and one for teens.

Conclusion

Even though Obsessive-Compulsive disorder is now recognized as one of the most common psychiatric disorder, people with the disorder are still going untreated and undiagnosed. Patients wait an average of 17 years before appropriate treatment initiated (Valente, 2002). It is important for therapists to educate the public on Obsessive-compulsive disorder. Early recognition and accurate diagnosis are very important. Still many people go untreated, so there is a need to increase the awareness of the disorder. The Yale-Brown Obsessive-compulsive Scale has become the most widely used tool for assessing symptoms (Valente, 2002). It has been translated into more than a dozen languages. Unlike other scales, the number of symptoms does not affect the Yale-Brown Scale; rather it assesses the extent to which the symptoms affect the individual life.

There are many options for a person with Obsessive-compulsive disorder; the resources need to be available. The quality of life a person with Obsessive-compulsive

disorder is very hard to understand. If a person does not have the disorder, it is hard to comprehend. The disorder can hinder a person's functioning at work, in school, or at home (Dunitz, 2001). It can affect relationships with co-workers, friends, and family.

A person who is affected by Obsessive-compulsive disorder may find it hard to accept. The person may feel angry, sad, or frustrated. The only way to get through it is to recognize there is a problem and do seek help. By going to a therapist, someone with Obsessive-compulsive disorder may feel some relief with a combination of medications. So many people have gone through life not knowing they had Obsessive-compulsive disorder. As Obsessive-compulsive disorder gets more recognition, maybe more people will reach out for help.

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