MANAS Speaks

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Manas Speaks is a monthly magazine from Manas-The academy of psychology, to publish a wide range of conceptual articles relating to different perspectives on methodologies in psychological research and to support student communities to strengthen their knowledge.

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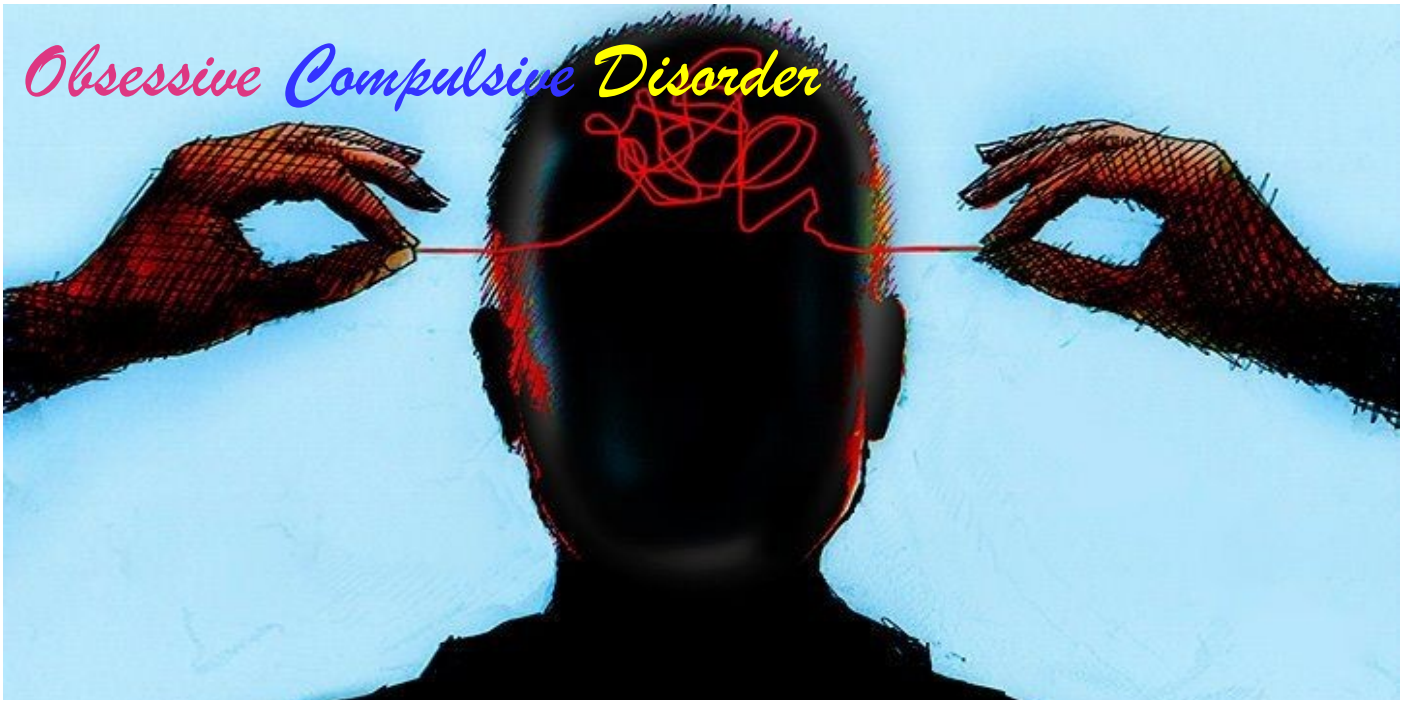
ARTICLE

Obsessive Compulsive Disorder



OCD known as obsessive compulsive disorder is a condition in which the client himself is more sufferer than anyone else who is in contact with him, as the very tragic point in this disorder is that he knows whatever thoughts, doubts, impulses are coming in his or her mind are involuntary, absurd, useless so he never wishes to welcome and tries to control them but unfortunately he finds himself helpless and more trapped in these. In social gathering he feels embarrassed, gets suspicious that people might knowing his condition, so gradually he starts avoiding the people and the situations which increase his doubts or rituals. Most of the time he develops depressive symptoms like low mood, decrease interest in all pleasurable activities, interaction, job, crying spells, hopelessness, helplessness, worthlessness and so as the ideas of suicide too which hamper his routine activities.

Initially the patient is unaware that the repeated thoughts are the product of any disease and family also does not notice. But when these repeated thoughts and activities start hampering his or her routine activities, question arises why the index person is doing so, many a times there is a critical comment or taunt that he does not want to do an act purposefully and doing these absurd things knowingly and as a result this worsen his mood and symptoms as stress is also the precipitating and maintaining factor in OCD.

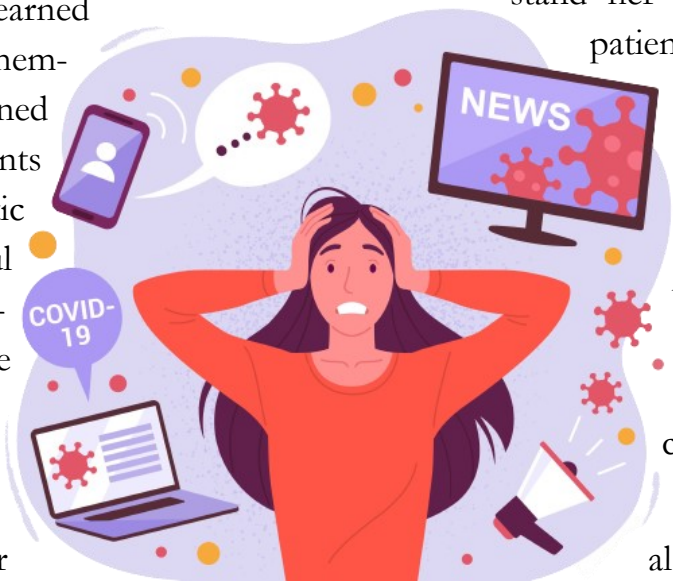
The OCD symptoms range from preoccupation, intrusive, repulsive, blasphemous thoughts to repeated checking, cleaning, avoidance, hoarding, getting assurance and reassurance. Genetic factors (family history of OCD or depression) and environmental factors (family disputes, marital conflicts, and any traumatic experience) may contribute in the genesis or maintenance of OCD. The severity ranges from mild to severe level as per YBOCS (Yale-Brown Obsessive Compulsive Disorder).

The cause of obsessive-compulsive disorder isn't fully understood. Main theories include:

Biology: OCD may be a result of disturbance of chemistry (neurotransmitters like serotonin, adrenaline etc.) or brain functions.

Genetics: OCD may have a genetic component as it is usually seen that a family member having OCD or depression or obsessive personality traits lead OC symptoms.

Learning: Obsessive fears and Compulsive behaviors can be learned from watching family members or gradually learned over time. Many patients report that any traumatic experience or stressful event (operant conditioning) or experience in one situation gets associated with another one (classical conditioning) triggers or maintains OC symptoms which trigger intrusive thoughts and compels a person to indulge in any compulsive ritual, subsequently causes emotional distress in the patient. Usually it is seen that OC symptoms get associated with one another and make a long chain e.g. if a patient thinks a shelf is dirty so all objects kept on it seems to be dirty and he starts avoiding these.



Problems resulting from obsessive-compulsive disorder may include:

Adjustment problems

Adjustment problem with family members as most of the family perceives as if the index person is doing the repetition just to pass the time in unnecessary works, instead of in some productive work so frequent fights, conflicts are the daily scene in such family.

The conflict may be due to excessive expenditure as patients report that due to excessive use of soap and water in washing hand or utensils disturb the family economy, patients report that they are compelled to throw the soap after every bath. One patient reports that she starts screaming when a water tank (capacity of 1000 Lt) is empty and generator does not work and family is unable to understand her condition. One another patient reports that when she doubts that her clothes get infected with urine droplets she can't resist herself to throw or give the dresses (costly one also) to maid and sometimes she also set the clothes in fire.

Marital disharmony also is a result of excessive thoughts of dirt and contaminations and compulsive washing. Patients report that after performing the coitus wife takes proper bath, changes the bed sheet, washes the room and compels husband to have a bath then and there only. Sometime this type of conflicting relationships result in separation or divorce.

Excessive time spent engaging in ritualistic behaviors

- Health issues, such as contact dermatitis from frequent hand-washing
- Difficulty attending work, school or social activities
- Troubled relationships
- Overall poor quality of life
- Suicidal thoughts and behavior

Prevention

There's no sure way to prevent obsessive-compulsive disorder. However, getting treatment (pharmacotherapy as well as psychotherapy) as soon as possible may help prevent ocd

from worsening and disrupting activities and daily routine.

Cognitive Behavior Therapy is the best choice of psychological treatment for OCD. The techniques used in this approach includes muscle relaxation (to reduce anxiety presentation), Exposure and Response Prevention (ERP) (for neutralizing and habituating obsessions, distraction techniques (backward counting etc,), Modeling (for motivating the patient about recognizing his potential and capability), family therapy (to make family members aware the disorder and cut their critical comments) which are maintaining their OCD and asking their motivational support and working as a co-therapist in the home environment.

ERP mainly focuses on confronting the situation. This helps the patients learn to do the opposite of what the OCD tells them to do, by facing their fears gradually in small steps (exposure), without giving into the rituals (response prevention). ERP helps them find out that the fears don't come true, and they can habituate or get used to the scary feelings, just like they might get used to cold water in the swimming pool.

While implementing ERP, the patients first reactions was that that might not be possible so they were not ready to try it. But modeling and cognitive restructuring make them enable to understand how exposure and habituation work and they will be more willing to tolerate the initial anxiety experienced during ERP because they come to know that it will increase first then subside. In home setting family members role is very important to increase the efficacy of CBT.

Typical presentation of OCD in a tertiary care hospital in day to day practice:-

Case 1:

A 27 year old postgraduate, unmarried girl suffering from OCD for last 15 years. The symptoms were obsession from getting harm from spices, pesticides, phenyl, laxman-rekha, cow dung, injection etc. The pt started avoiding with the fear that spices will enter in her eyes or she may consume pesticides she stopped doing all household works and started remaining in her room only subsequently she also developed associated symptoms of depression like sadness of mood, crying spells, irritability, lack of confidence and concentration, hopelessness and suicidal ideation.

On YBOCS total score fell 37 (extreme). Item 1-5 score was 20 and item 6-10 it was 17.

She took treatment from multiple hospitals of Punjab with no result. After two years of treatment (drug therapy and psychotherapy) she improved and is maintaining well with regular follow-ups.

After treatment her score reduced to 4.

Case 2:

Another example of a 43 year old postgraduate married lady working as a data operator in a Govt. school developed symptoms after suffering from menorrhagia. After hysterectomy she saw that the sanitary napkin was placed on the table where her treatment file was also kept, now started a chain of symptoms and she perceived every place where that file touched dirty. She started cleaning her house, door knobs, currency notes, worship place, husband' bike, phone, purse with surf and phenyl etc. Even she got so vigilant that she started washing and wiping the handles and doors and street road of neighbor with phenyl. Consequently her hands got allergic but she was least bothering about it.

She also involved her husband and son in cleaning and washing their shoes and other belongings as they were scared of the severe conflicts created in the house. Her son's study was severely affected as she was not allowing him to touch the books and at one occasion her husband landed in to depression and suicidal too.

Her relationship with her family members got restricted because she would not allow anyone to enter in her house otherwise she repeated the washing sequence or did not cook food for days together without any consideration that her husband and her 17 year old son were hungry.

She avoided taking food and her purse in her office with the fear that her colleague might be menstruating and placing her belongings on the common table. After coming back from her office around 7-8 p.m. she used to take bath irrespective of any weather conditions.

YBOCS score on item 1-5 was 16 and item 6-10 was 17.

She took treatment from a private psychiatrist but her drug compliance was very poor. Her motivation was also very poor because of her poor insight.

Family support from her husband and his continuous efforts kept on bringing her to the psychiatrist and psychotherapist.

Psycho education regarding her nature of illness, its course and outcome and regular compliance with medicine and psychotherapy were very well explained.

Husband was also counselled how to cut reinforcement which were contributing and maintaining her symptoms.

She was put on psycho therapy. Initially she was not motivated for 6-7 sessions. Progressive Muscular Relaxation was taught. After repeated exposure and prevention and correction in her core dysfunctional beliefs she started complying the instructions and stopped asking her husband and son to wash their daily use belongings.

She also reduced use of phenyl (from one bottle per day to one bottle in a week). She started cooking food and touching the door handles and knobs with her hands. But if any time accidently she sees any sanitary pad in a street, all those thoughts recur in her mind and it is very difficult her to control them.

She has started taking her tiffin box and water bottle and purse in her bag to her office.

Still she is on treatment and psychotherapy.

At last visit her reduced score on item 1-5 was 6 and item 6-10 was 4.

Some cases are such who are having obsessions of specific numbers and words.

i) A 30 year metric pass, married, farmer by occupation was obsessed with some Urdu words like DUNIA (world), ARAB (country), ARBI (a vegetable), crore (currency) for last 3 years. He was so afraid with these words that he doubts that hearing and speaking such words will create havoc in his life and in the world too. He would not allow any family member to speak these words in front of him. This vegetable has not been cooked in the family. And if accidently he hears any of such words he develops anxiety symptoms like shivering of his body, trembling of limbs and speech difficulty in breathing, over sweating and irritability.

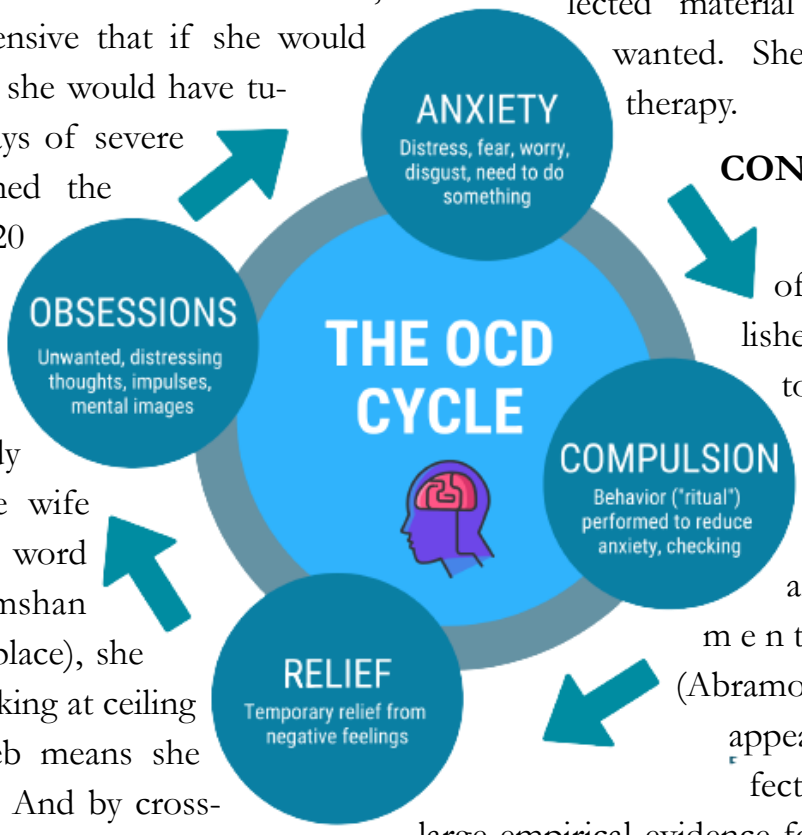
ii) Another case refers to a 40 years old married house wife belonging to a joint family was scared of words pertaining to diseases like cancer, tumor, HIV, AIDS etc. whenever she was exposed by such words from holdings or read from a book, she doubted that she would be caught by such fatal diseases so she repeatedly washed her hands or took bath. Once she bought a gold set costing 80 thousand but while coming back she had seen a holding on which an advertisement of tumor was there, she got so apprehensive that if she would wear this ornament she would have tumor. After three days of severe conflict she returned the set with a loss of 20 thousand.

iii) One more case is worth to mention. A married lady of 35 years, house wife was scared of the word 'Fan' and 'Shamshan Ghat' (a mortuary place), she doubted that by looking at ceiling fan or cleaning web means she would hang herself. And by crossing mortuary place, she will have cremation. This indicates that she was scared of death so she avoided such objects and places and news regarding death in spite of knowing that this cannot be done.

Above cases were treated by written and spoken exposure of such words and then verifying the consequences with cognitive restructuring. After 4-5 sessions these cases were free from such obsessions and associated anxiety symptoms.

A very interesting case is worth to mention about a 50 years old married, house wife who was attracted to small pieces of papers, sticks, buttons, wrappers, and cement from wall. She used to collect these objects and keep them in a polythene bag then in her almirah and lock it. She never allowed her husband and daughter to touch it. She thought it was useless but she got satisfaction in storing these things and never tried to resist such attraction.

After 5-6 sessions she had thrown those collected material which she never wanted. She discontinued the therapy.



CONCLUSION:

Over a period of 50 years of published research has led to the wide consensus among researchers and clinicians that CBT is an effective treatment for OCD (Abramowitz JS 2006) ERP appears to be most effective. Based on the large empirical evidence for ERP it is recommended as the first-line treatment for OCD, with CBT as an alternative as per the research available. Clinical researchers should continue to refine CBT programs to maximize improvement and make treatment more palatable to those in need of help. It is difficult to determine the usefulness of psychological interventions other than ERP and CBT because of lack of control studies. More work also needs to be done to determine how to best tailor treatment to individual needs.

- Dr. Mamta Bahetra