

What Is OCD and Is It Really a Problem?

This chapter will examine a brief overview of obsessive compulsive disorder (OCD) and its defining features. Public perception of OCD over time will then be appraised, from the low awareness that existed throughout much of the early twentieth century to the present, when it is almost fashionable to claim that an individual is ‘a little bit OCD’.

The chapter will then examine what distinguishes ‘normal’ obsessions and compulsions from those that are detrimental to the individual and their functioning. Finally, the chapter explores how obsessions and compulsions may have evolved and how they may give the individual a biological advantage.

What Is OCD?

Obsessive compulsive disorder is one of the most overlooked and frequently misdiagnosed conditions. People often talk about a friend or family member being ‘obsessed’ by a particular football team, a hobby, or a girlfriend/boyfriend. In addition, someone who is organised, works hard, and is generally neat and tidy may describe him- or herself or be described by others as ‘slightly OCD’. The behaviours in these cases are often very different from the extreme symptoms with which many patients with OCD suffer.

A person with OCD has two major symptoms: obsessions and compulsions. Obsessions are troublesome and persistent thoughts or impulses which appear in a person’s mind and result in anxiety, horror, or disgust. Because these thoughts are often so unpleasant, the person will resist the thoughts and try to ignore them or force them away. Unfortunately, trying to push the thoughts away often results in them recurring more frequently. These obsessive and intrusive thoughts are generally the worst thoughts that the individual can imagine. For example, a religious person may have blasphemous thoughts; a gentle and loving parent may have images of harming their child; or a person with high moral standards may have worries that they have been acting in an inappropriate sexual way towards another, despite evidence to the contrary.

Obsessive thoughts cause the person to be very anxious and uncomfortable. Normally when a person is frightened, they will attempt to escape from the

situation. In the case of anxiety-provoking thoughts, it is impossible to escape from them; as a result, a number of compulsions are developed. Compulsions are thoughts or behaviours which are designed to reduce or prevent the harm of the obsessive thought. However, either they are not realistically linked with the obsession or they are clearly excessive. Compulsions tend to reduce anxiety, and because high anxiety is unpleasant, the decrease in anxiety following the performance of a compulsion is rather like a reward to the individual. If you reward any behaviour, you increase the chances of it happening in similar circumstances in the future. This means that by causing a reduction in anxiety, the tendency to perform compulsions becomes stronger the more they are repeated. In addition, compulsions will only slightly reduce anxiety over a short space of time, and so individuals will repeat the compulsive behaviours until they feel 'right' or until another thought distracts them.

Case Study 1.1

Anne is a 30-year-old married woman who used to work as a teaching assistant. She has always been a conscientious and capable woman, and she worked hard at her job. After giving birth to her daughter Lily at age 28 years, Anne became increasingly worried that she might 'poison' Lily with dirt and germs, which would result in Lily becoming ill or dying. Most mothers worry about cleanliness around a baby, but in Anne's case, this quickly got out of control. She was not content with using sterilising fluid on Lily's utensils; rather, she would repeat the action many times. In addition, she began to wash her hands increasingly until she was eventually washing them more than 100 times a day. Once Lily was mobile and walking around, Anne began to clean every area where Lily might play and then began to prevent Lily from playing outside. Anne realises that her concerns are excessive, but due to her overwhelming anxiety, she is unable to ignore her thoughts and she feels the urge to 'play safe' by performing her compulsive rituals.

In Anne's situation, her compulsions are linked to her desire to be a good mother, but her worries and her 'decontamination' compulsions are excessive and beyond normal cleanliness. This overconcern about Lily is actually restricting Lily's ability to learn and play and to explore the world.

Case Study 1.2

Amy is a 25-year-old woman who fears that she might cause a catastrophic fire if she does not ensure she has turned off all electrical appliances and the gas cooker. After using appliances, she repeatedly checks that they are switched off, returning up to 50 times. In the past two years, she has tried to avoid using all

electrical or gas appliances and asks her mother, with whom she lives, to use these for her. If she does have to use an appliance, she will repeatedly ask her mother for reassurance that she has not caused a fire. Her mother will reassure her, but a few minutes later, Amy will ask again, and this can continue for many hours until Amy has a new worry. If Amy's mother refuses to answer the questions, Amy becomes extremely tearful and upset, and her mother will then relent and give her the reassurance.

Amy's story shows that compulsions can sometimes take the form of reassurance seeking. Just like checking, counting, and decontamination compulsive rituals, these activities can also slightly reduce anxiety. Because high anxiety is unpleasant, this reduction in anxiety is similar to a reward. If any behaviour is 'rewarded', the chance that it will reoccur in similar circumstances increases. This means that the compulsions increase the more they are repeated. By providing reassurance, Amy's mother is trying to help her daughter and alleviate her distress but is accidentally making the situation worse.

Case Study 1.3

Jim is a 35-year-old man who has always wanted to ensure that he does the 'right' thing, and he prides himself on holding high moral standards. He was popular in school and left school having passed his exams. There were no obvious signs of OCD during his early life, and he had close friends, although he had never formed a lasting sexual relationship. Jim has worked as a security guard since leaving school, and he managed well until four years ago. At that time, Jim read about some high-profile celebrities who had been involved in child sexual abuse. Jim was appalled and shocked by these revelations and was clear that he believed such behaviour was 'evil'. However, he began to check that he himself had not inadvertently sexually assaulted a child. These concerns have led him to completely avoid any place where there may be children. Parks, roads with schools or nurseries, and even buses at peak times before and after school have become 'out of bounds' for Jim. If he does unexpectedly see a child, he will tightly squeeze his hands into fists, cross his arms across his body, and stand totally still until they leave. This behaviour is an attempt to ensure that he does not 'lurch at the child and assault them'. Once they have passed, he still doubts himself and repeatedly taps his right foot on the ground in multiples of 20 until he feels sure he remained motionless on the spot when the child went past. Occasionally, he has been stuck in this position for 15–20 minutes after seeing a child. Jim realises that this behaviour is unconnected with his fears, and he understands that he has not attacked a child. Nonetheless, the fear is so great that he feels compelled to perform the compulsive foot tapping. Occasionally, he has placed himself in danger as a result of this behaviour by becoming 'stuck' in the middle of busy roads. The OCD has also resulted in Jim having to stop working due to his attempt to avoid children.

In the case of Jim, it is clear that the obsessional thoughts are completely abhorrent to him, and he is the opposite of someone who would enjoy sexually abusing children because he finds the thought so awful. His behaviours to avoid this are excessive and, in the case of the foot-tapping compulsion, are not actually connected with the obsessive fear. In addition, Jim's story demonstrates his increasing avoidance and restriction of daily activities due to OCD.

People with OCD tend to progressively avoid objects or situations which provoke the obsessive thoughts. Due to this avoidance, their lives can become increasingly more restricted and limited. This is demonstrated in the previous case studies. Anne increasingly handed over some of her child care to either her mother or her husband as her fears progressed. Amy increasingly stopped using electrical appliances and demanded her mother cook and switch off appliances for her. Jim's life became increasingly restricted as he avoided all areas where children and young people might be present.

But We All Have Some OCD, Don't We?

Most of us experience some kind of obsessions and compulsions. Many people will, for example, throw salt over their left shoulder in response to spilling salt, due to a European belief that this will scare the devil away. Others will salute or cross their fingers if they see a solitary magpie, which has traditionally been linked with sorrow. These behaviours are similar to obsessions and compulsions, but they tend not to be repetitive and also do not cause extreme distress or interfere with a person's ability to perform normal activities of daily living.

Obsessive thoughts have been experienced by many of us when standing on the top of a high building or on the platform as a train is about to arrive and we suddenly have the thought or urge that we may throw ourselves over the side. This thought is unpleasant, and we may take a step back. Similarly, most of us have experienced sudden violent, blasphemous, or inappropriate sexual thoughts. Generally, we will have these thoughts and then dismiss them as being 'stupid' or 'inappropriate' and forget about them. It appears that most people with OCD are not able to do this. Many will have a thought and find it so overwhelmingly unpleasant or worrying that they try very hard to never have that thought again. Of course, once you try *not* to have a thought, the thought will continue happening as you keep it in your mind.

The fact that all of us experience some obsessions and may perform some compulsions shows that along with many other psychological and mental disturbances, OCD is on a spectrum. Although it is not difficult to recognise that people who are spending almost all their time preoccupied by their obsessive fears and compulsive rituals have a problem, people often ask the question, 'When is OCD a problem that needs help?' The answer to this question depends on the individual. OCD traits seem to be at least partially genetically inherited. Some of the traits that many OCD patients have – being conscientious, meticulous, and punctual – are clearly an advantage in life. There is no mystery in the fact that many sufferers of OCD have been highly successful as doctors,

nurses, accountants, lawyers, secretaries, and journalists and in other professions which require high attention to detail and the ability to concentrate well for hours on end. It is easy to see that there may be a biological advantage to humans to have some obsessive traits. Avoidance of excrement and disgust are traits which humans share with many other animals. From the Stone Age (or even earlier), an individual who avoided faeces would clearly have a biological advantage over one who did not. Similarly, someone who was persistent and meticulous would also often have an advantage in survival terms over someone who was not. However, it is when these traits become overwhelming and take over every other aspect of the individual's life that the issue becomes a problem.

Case Study 1.4

Geoff is a 25-year-old man whose parents were both doctors; his mother worked as a general practitioner, and his father was an orthopaedic surgeon. The family has three children. The eldest child, George, is a solicitor working in a successful law firm. Molly, the middle child, is an academic historian working at a prestigious university. Geoff was similarly a high-achieving scholar in the early years of his schooling but began to fail to achieve predicted grades once he reached the age of 13. His parents were concerned at the time, and Geoff was seen by a child psychologist. Not wishing to admit to the problems he was experiencing, Geoff denied any difficulties despite the evidence to the contrary. The family was offered family therapy, and Geoff's teachers believed he was experiencing 'adolescent rebellion'. In fact, Geoff had become concerned that he had to get everything perfect and correct or else he would feel a failure. He was not able to describe what 'being a failure' may constitute except that it was a 'terrible, bad thing' and that his family and friends 'would not respect' him. Occasionally, he admits that he believes that not being perfect would lead to him being abandoned by everyone he loves. He finds this thought so frightening that he becomes paralysed with fear, checking that everything he does is performed 100 per cent correctly. For example, he was meticulous at school with his handwriting and, consequently, he was predicted to easily pass his school examinations with the highest grades. However, he failed or gained borderline grades due to his meticulous attention to detail, resulting in his inability to complete the examinations within the allotted time.

As the years passed and his fear of failure continued, his symptoms worsened. Currently, he is unable to perform any activity without extreme distress. Washing and bathing take up to eight hours as he tries to ensure that he washes his body perfectly. Consequently, he has given up his daily bath and now showers when he believes he 'has the time'. This has meant that he has not bathed for more than six months. Similarly, his fingernails and toenails are long and curled because he cannot bear to make a mistake when trimming them. His hair is matted and unkempt, as otherwise he would worry that the barber had not cut his hair perfectly straight. Wearing a long straggly beard because he is unable to attempt shaving, he makes a sharp contrast with his pristine and well-groomed parents and siblings.

Summary

The history of Geoff shows that his high-achieving and slightly perfectionist family members all managed to succeed in life in spite of, or maybe because of, these characteristics. Geoff, on the other hand, became so caught up in perfectionism that it has impaired his ability to function in activities of daily living and his ability to work. It is clear to everyone that Geoff's fear of performing an action imperfectly means that he is far from perfect – the situation he is fearful of! This 'all-or-nothing' or 'black-and-white' thinking is frequently observed in people with a desire to achieve perfection. They seem unable to compromise and are happier to accept the state of total failure rather than try to perform an action and risk not doing it perfectly. In other words, they seem unable to find the 'happy medium' and be 'good enough' rather than perfect. Realistically, perfection is not a normal human state, and anyone who seeks to achieve it is likely to fall short to some degree. It is more realistic to try to arrive at a happy compromise of being 'fit for purpose'!

Key Points

- Obsessive compulsive disorder (OCD) consists of obsessions and compulsions.
- Obsessions are thoughts, ideas, images, or impulses which are deeply unpleasant and result in increased anxiety or distress.
- Compulsions are thoughts or actions which are designed to reduce or prevent the effect of the obsession. However, either they are not realistically related to obsessive fear or they are clearly excessive. Many patients seek repeated reassurance from their friends, family, or others as a form of compulsive behaviour.
- Avoidance is also frequently seen in people with OCD. People will often progressively avoid objects and situations which may provoke the OCD thoughts. The consequence of this avoidance is that the individual may live an increasingly restricted life and may end up unable to work or socially very isolated.
- The symptoms of both obsessions and compulsions are found in the general population amongst people who do not necessarily suffer from OCD. The difference between obsessions and compulsions in OCD and these more 'normal' obsessions and compulsions is that they do not take over the person's life nor do they restrict the person's ability to achieve their life aims.