

Obsessive-Compulsive Disorder: What is OCD?

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Obsessive compulsive disorder (OCD) is an anxiety disorder that afflicts between 1% and 2% of the population at some point in their life. OCD is characterized by the presence of obsessions and/or compulsions that are recognized by the sufferer as excessive, unrealistic, may be even senseless, and that cause marked distress, are time consuming or significantly interferes in daily activities.

Obsessions are repetitive and persistent unwanted, unacceptable and distressing thoughts, images or impulses that are difficult to control despite a person's strongest efforts at trying to resist. Obsessions often deal with troubling, repugnant, or even nonsensical, themes that may be entirely inconsistent with an individual's personality and values. The most common types of obsessions are fears of dirt or contamination, excessive doubt over one's actions or conversation, unacceptable aggressive thoughts or impulses, ideas of disgusting sexual behavior, religious blasphemy, or impulses to achieve exactness and order, or to maintain a rigid routine.

Compulsions are repetitive, fairly rigid behaviors or mental reactions that usually occur in response to a distressing obsessive thought. Most often the compulsion is performed to relieve distress caused by the obsession or to prevent some feared consequence. Even though a person may initially resist giving into a compulsive ritual, he or she will eventually yield to the ritual because of a strong urge. Frequent washing or cleaning, checking, repeating specific phrases or re-doing certain actions, slowness, hoarding or rearranging objects are common forms of compulsions. Usually the person experiences a temporary sense of relief after satisfactory completion of a ritualistic sequence but in the long-term the compulsion simply strengthens the obsession, thereby perpetuating a vicious cycle of recurring obsessions and compulsions.

Compulsive washing and checking are by far the most common types of OCD. For the person with compulsive washing rituals, perceived contact with a dirty or potentially contaminated object can trigger the obsessive thought

“I might have come in contact with germs and could get very sick”

In response to this very distressing thought, individuals might repeatedly wash their hands until the distress has subsided and/or until they are convinced that the germs (i.e., threat) have been removed. In compulsive checking, the person may doubt whether the door is locked and so return repeatedly to check the doorknob until they are reasonably convinced that the door is indeed locked. Because the cycle of obsessions and accompanying compulsions can be so distressing and time consuming, the preferred strategy for many people with OCD is to restrict their lives in order to avoid objects or situations that might trigger the obsessional fear.

OCD is known to occur in children although the more usual age of onset is adolescence or young adulthood. The age of greatest risk for onset is 18 to 24 years with only 5% of individuals with OCD reporting an initial onset after 40 years of age. Obsessions and compulsions can have either a fairly sudden or a gradual onset, often in response to some stressful period in a person's life. Once the disorder develops, it often takes a chronic course with symptoms waxing and waning over many years. It is rare for OCD symptoms to spontaneously disappear without some form of treatment. The symptoms often become worse with stress or other life problems, and then recede into the background during relatively calm or stable periods in one's life. Unlike many of the other anxiety disorders, women with OCD only slightly outnumber men. The incidence of OCD seems fairly consistent across cultures, although cultural and ethnic differences appear to influence the symptom expression of the disorder. People with OCD often suffer from other types of psychiatric conditions, the most common being major depression, social anxiety, and, to a lesser extent, panic disorder. Severe forms of OCD can have a serious negative impact on [educational achievement](#), occupational success, employment status, and the quality of relationships with family and friends.

Faulty Thinking in OCD

Even though disturbed thoughts and images are an important part of OCD, for many years psychologists and psychiatrists assumed that negative cognition did not play a significant role in the cause or persistence of the disorder. The emergence of obsessions and compulsions was understood in terms of biology and an unfortunate [learning](#) history. However in recent years psychologists have begun to explore the cognitive (thoughts and beliefs) basis of OCD. This has led to new insights into the disorder and better psychological treatments for obsessional rumination, in particular.

This new cognitive approach to OCD has led to three important findings about the nature of the disorder. First, pioneering research by Dr. Jack Rachman and colleagues led to the discovery that most people have occasional *unwanted intrusive thoughts, images or impulses* that are very similar in content to the obsessions suffered by individuals with OCD. If practically everyone has troubling thoughts of contamination, violence and doubt, then why are these thoughts so much more frequent, distressing and impairing in the person with OCD?

This question led to a second significant finding about the cognitive (thoughts and beliefs) basis of OCD. New research indicates that individuals vulnerable to OCD may be more inclined to engage in a *faulty appraisal or evaluation* of certain unwanted intrusive thoughts. Recent research findings are beginning to unravel the type of cognitive evaluation that might turn an occasional intrusive thought, such as "Could I actually lose control and hurt an innocent person?", into a frequent and highly distressing obsession about violence and harm toward others. For example, a person may believe that these violent thoughts are significant because they are an indication that one might actually lose control and harm others. They may also believe that they are responsible to prevent even the possibility of harm, and therefore they must

get control over their intrusive violent thoughts. This person is likely to focus a great deal of attention on these violent intrusive thoughts. The thoughts will become a major mental disruption that must be eliminated.

The faulty appraisal of an intrusive thought of contamination, violence or doubt as a highly significant threat that one is personally responsible to control will lead to efforts to neutralize the thought and its associated distress. Third, cognitive-behavioral researchers have discovered that *neutralization* strategies, that is any attempt to remove, prevent or weaken an obsessional thought or its associated distress, will surprisingly, lead to an increase in the strength of the very thought the person is trying to remove or suppress. Compulsive rituals have a neutralizing function, as does persistent reassurance seeking, or other forms of intentional mental control. The negative impact of neutralization is clearly evident in the person with compulsive checking rituals who may repeatedly check a document many times in response to obsessional doubts that he or she has completed the form perfectly. The purpose of the checking is to prevent the possibility that a mistake was made and to reassure the individual that all is correct. However the checking never completely neutralizes the distress associated with doubt because the person can never be certain that a mistake has not been made on the document. In this way compulsive rituals and other forms of neutralization inadvertently end up perpetuating the very obsessions they seek to address.

Cognitive Behavioral Treatment of OCD

In the 1970's a very successful behavioral treatment for OCD was developed by Drs. Rachman, Marks and Foa called *exposure and response prevention* (ERP). Originally introduced by Victor Meyer in 1966, ERP involves the systematic, graded exposure to successively more fearful situations that elicit the obsession while at the same time preventing the person from performing the compulsive ritual or any other form of neutralization. For example, a person with a washing compulsion with the thought "I will be contaminated from the dirt", might be initially asked to handle books that other people handled (moderately distressing), then wash clothes in a public laundromat (more distressing), and then finally use a public toilet (highly distressing). The person would engage in a series of exposure sessions that could last 1-2 hours at each fear level while at the same time being prevented from washing. Once the fear has subsided at one level, the person then proceeds to the next fear level. Because fear or distress tends to extinguish if a person remains in the fear situation for a long period of time, repeated prolonged exposure with prevention of a compulsive ritual will eventually lead to significant reduction in the obsession and its associated distress. Most individuals with OCD will realize significant improvement with ERP after just 15 – 20 sessions.

The American Psychological Association Division 12 Task Force on Promotion and Dissemination of Psychological Procedures classified exposure/response prevention as a well-established, empirically supported treatment for OCD. It is considered the treatment of choice for mild to moderate OCD, and should be combined with psychiatric medication for more severe

cases. Approximately 80% of individuals with OCD will experience significant symptom improvement with exposure/response prevention treatment and treatment gains can be maintained over many years. Moreover exposure/response prevention treatment may produce better treatment outcome than medication alone at least when assessed at the point of treatment termination.

Exposure/response prevention treatment is now incorporated into most standard treatment programs for OCD offered in leading anxiety disorder treatment centers. However, ERP has its limitations. Exposure/response prevention treatment does not work for everyone. Approximately 75% of individuals who complete a trial of ERP improve and 25% do not. Another 20% to 30% refuse to participate in ERP because it involves exposure to fear situations that is distressing to them. Exposure/response prevention treatment is less effective for obsessional disorders without overt compulsions.

In response to these concerns, new treatment protocols for obsessions have been developed that incorporate cognitive interventions along with exposure and response prevention in order to modify the faulty appraisals that perpetuate obsessional thinking. This new cognitive-behavioral therapy for OCD consists of educating the person with OCD about the cognitive nature of their obsessional problems, and how to identify their automatic faulty interpretations of the obsession and their counter-productive neutralization strategies. New thinking tools and strategies are used to modify the faulty interpretation of the obsession. Together the client and cognitive therapist explore healthier alternative ways to view the obsessional concerns. Specially designed behavioral experiments, including exposure and response prevention, are used to assist the client in the development of an approach to obsessions and compulsions that will reverse their vicious cycle and weaken the OCD. The goal of treatment is to help individuals with OCD achieve a change in attitude and behavior toward their symptoms so the obsessional thought is normalized. That is, the client comes to view the mental intrusion as insignificant, non-threatening “thought” that is most effectively handled by simply “doing nothing”.

A number of treatment trials are currently underway to assess the effectiveness of this newer cognitive-behavioral treatment for OCD. The preliminary findings are encouraging. Even though cognitive-behavioral treatment for OCD is in the early stage of development and testing it does offer new hope for those suffering from OCD. In recent years our understanding of obsessive compulsive disorder has significantly increased. Obsessive compulsive disorder is a very treatable problem. 75% of people who complete exposure/response prevention treatment get better. New treatment protocols are being developed for people who do not benefit from traditional exposure/response prevention therapy. This newer treatment hopefully will increase even further the number of people who can benefit from therapy.

For further reading suggestions or to get more information about recommended books, click on the book of interest and you will be directed to Amazon.com, which describes the book in more detail (some references may not have links if they are not available through Amazon.)

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Consumer Resources on Cognitive and Behavior Therapy for OCD

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