Understanding obsessive

Get to know this serious and debilitating mental disorder.

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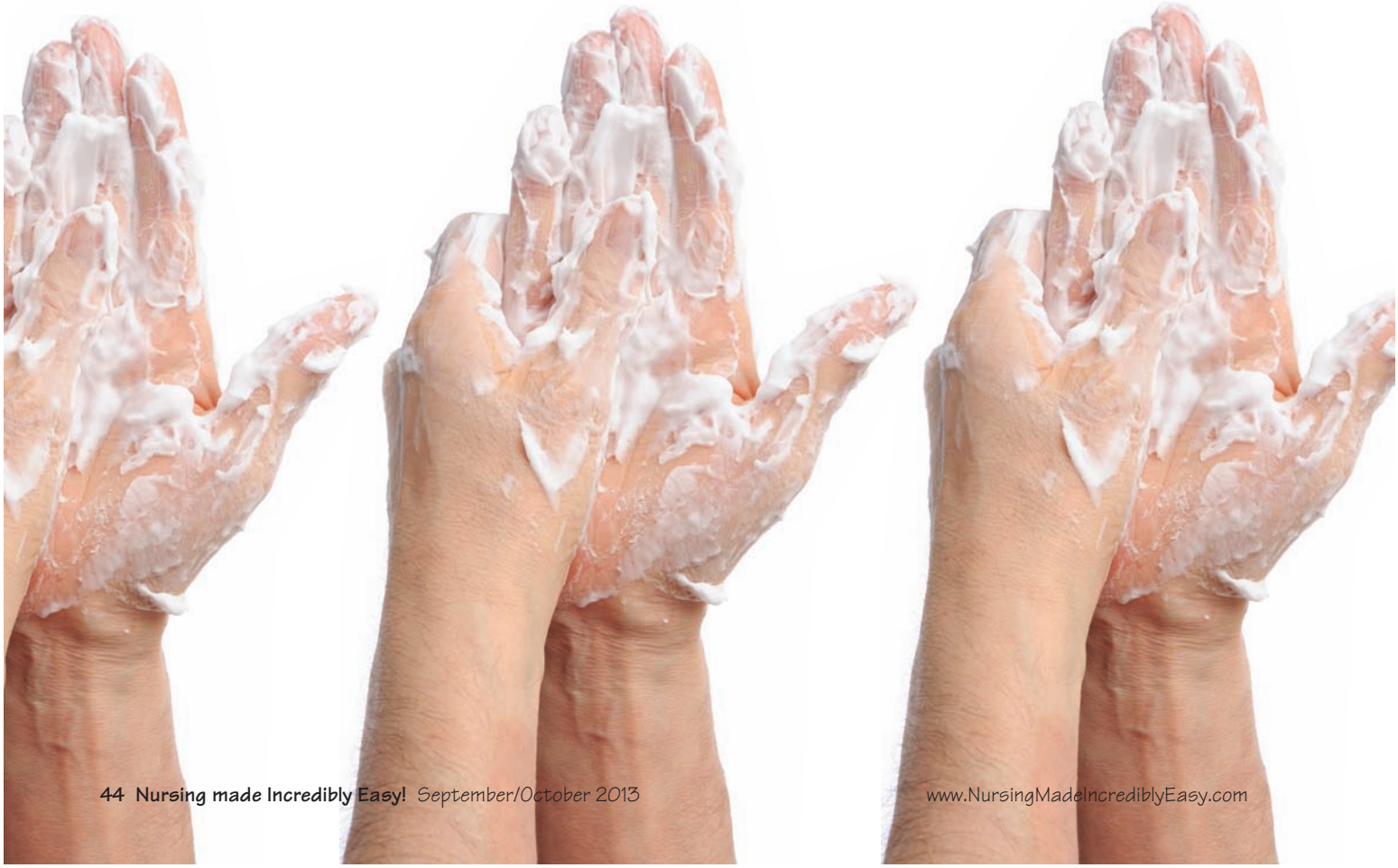
Mr. S is admitted to a psychiatric inpatient unit at a local hospital. His primary psychiatric diagnosis is bipolar affective disorder, type I, and he's hospitalized for treatment of a mixed episode, experiencing agitated depression and suicidality.

Previously, he had completed two undergraduate college degrees while working full-time as a cab driver in our mid-size city. However, several years ago, Mr. S became depressed and lost his job. A diagnosis of bipolar affective disorder followed.

Mr. S began treatment, looking for a job and starting a charity that provides clothing and school supplies to kids in need. He spoke openly about his bipolar disorder diagnosis to friends, family, and coworkers but until this hospital admission, he had never disclosed the worries and rituals that made day-to-day life an incredible struggle.

He's worried about germs and infection, and has difficulty leaving his apartment without completing many counting and checking rituals. To Mr. S, these behaviors are shameful and embarrassing. Although he embraced his bipolar diagnosis, his obsessions and compulsions are a deep secret. Mr. S is diagnosed with obsessive-compulsive disorder (OCD).



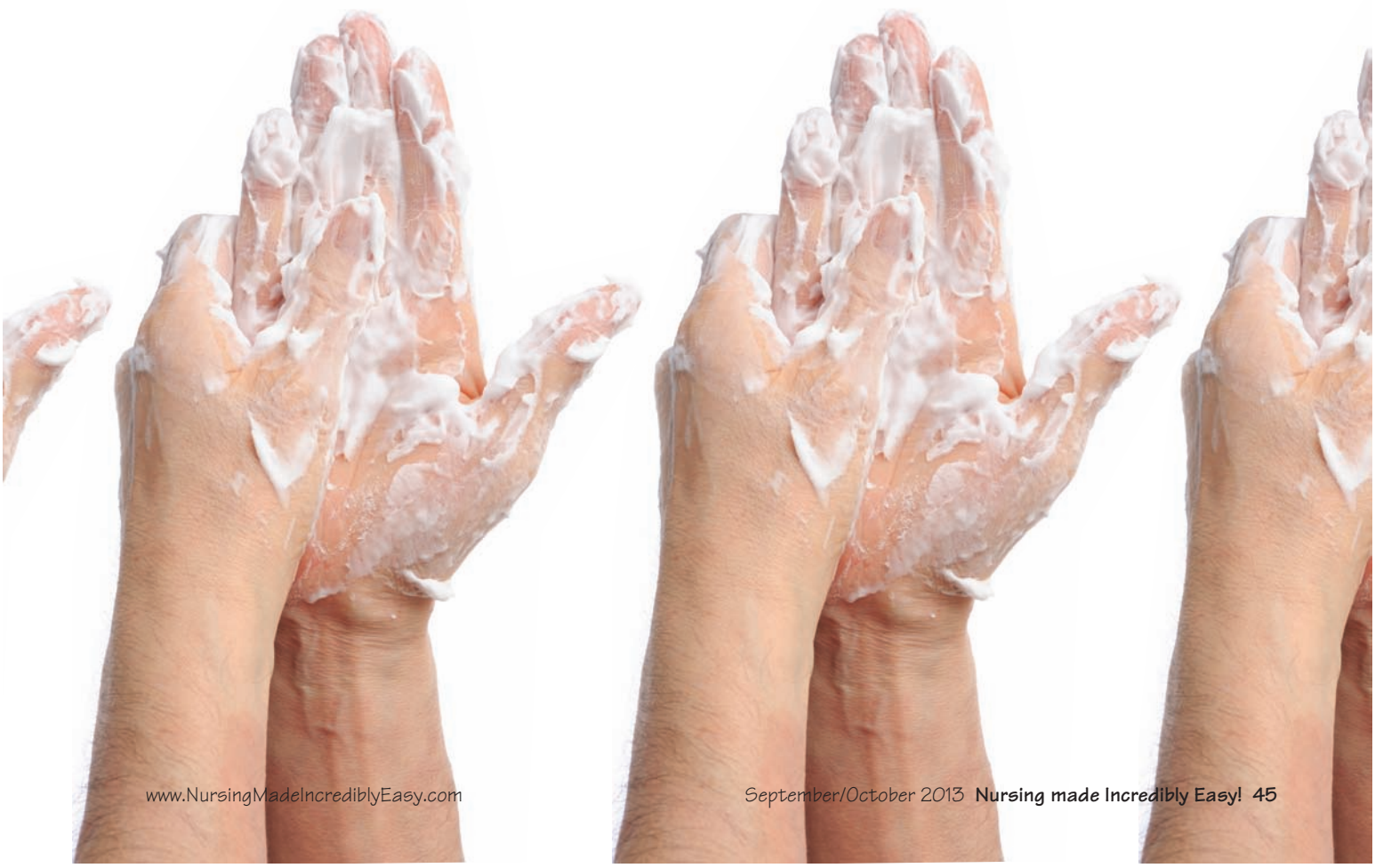
-compulsive disorder

Facts and figures

OCD affects 1% to 3% of Americans. The National Institute of Mental Health reports the lifetime prevalence of OCD as 1.2%. Of the roughly 3 million people who'll be diagnosed with OCD during their lifetimes, about half are characterized as having severe symptoms. The average age of onset is 19, although most individuals with OCD report that they had OCD-like symptoms in childhood (see *OCD in children*). Early onset of OCD is associated with more severe illness.

When OCD is untreated, it has a chronic and unremitting course; it doesn't get better or remit without treatment. In a survey of 560 patients, 85% reported a continuous course of illness with periods of waxing and waning symptoms, 10% reported progressive deterioration, and 2% reported illness with intermittent periods of full remission. Stressful events, such as becoming a parent or experiencing a trauma, can trigger the onset of OCD or make it more severe.

OCD is frequently comorbid with other disorders, such as depression, panic disorder,



generalized anxiety disorders, eating disorders, and Tourette syndrome. Studies indicate that about one third to more than half of the individuals with OCD have at least one comorbid mental disorder.

Making the diagnosis

The recently updated fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* moves OCD into a new category, grouped with body dysmorphic disorder, trichotillomania (pulling hairs out), hoarding disorder, and excoriation (skin picking) disorder. This change reflects a consensus that these disorders are similar in symptoms (characterized by driven, repetitive behaviors), neurobiologic substrate, disease course, and heritability, and that they respond to similar treatments.

A diagnosis of OCD is made when obsessions or compulsions are noted and have a significant adverse effect on important aspects of an individual's life. People say "I'm a little OCD" when talking about being a "neat freak" or wanting to double check that they've locked the car. However, "a little

OCD in children

OCD is typically diagnosed in adults; however, it also appears in children. The prevalence of OCD in children is identified as somewhere between 0.5% and 3% of the pediatric population. Most adults with OCD state that they've had obsessions and compulsions throughout their lives. Normal development may make it difficult to recognize obsessions or compulsions in children.

Many children, particularly when very young, have strong urges to make things "just so." Routines and rituals may develop around age 2 and wane by age 5 or 6. With childhood onset of OCD, routines or rituals develop and intensify, without subsequently declining. Some research suggests that OCD rituals may differ in content from normal childhood routines. Common childhood rituals concern orderliness and superstition. In contrast, OCD rituals often involve cleanliness, checking, and repeating.

Many children also have periods during which they experience fears or thoughts of guilt and shame, or may worry about germs or contamination. In the general pediatric population, these thoughts and behaviors tend to decline as children mature. In the case of OCD, these thoughts and behaviors persist and pose significant problems for the child and family.

Although the presence of obsessions and/or compulsions is needed for a diagnosis of OCD in children, an important distinction is that the child doesn't have to recognize the thoughts or behaviors as excessive or unrealistic.

The presentation of OCD in children may be described as selective. In many cases, the affected child maintains the ability to be successful at school and in extracurricular activities. These children may appear normal to a casual observer. However, a closer look at daily function might reveal significant time given to cleaning, checking, or ordering rituals, or many hours a day during which the child seeks reassurance about something.

Children with OCD may describe getting "stuck" and being unable to complete daily activities or chores, such as bathing or doing homework. In many cases, the child's caregivers are involved in completing a part of the ritual. The caregiver may feel forced to participate to placate the child and preserve household functioning.

Although adults with OCD frequently feel that there's something shameful about their thoughts or behaviors and, as a result, keep them hidden, children may lack this presentiment. Nonetheless, it's common for children to be secretive about their obsessions or compulsions. The child's caregivers may hide or minimize the impact of their child's behaviors out of embarrassment or the notion that it's "just a phase."

Abrupt onset of obsessions and compulsions, together with tics, extreme anxiety, and mood lability, following streptococcus infection has been noted in some children. Researchers have hypothesized that this derives from an autoimmune response in the wake of the infection that adversely affects the basal ganglia in the brain. This has been identified as pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS). The evidence for PANDAS remains mixed, however, and the syndrome is provisional.

When OCD has been identified in a child, the nurse plays an important role in supporting the family and caring for the child, as well as in helping the child continue to meet developmental goals and improve success at school and in social settings. You can help the family identify how they may have become involved in completing rituals and determine ways to support the child in reducing these behaviors. You can also support the family in maintaining positive and nurturing relationships with the child. The nurse's role as a nonjudgmental advocate for the child and the family as they identify target behaviors and engage in treatment can't be underestimated.

OCD" isn't OCD. In OCD, obsessions or compulsions are recurrent and severe, causing significant distress and making it difficult to maintain relationships, keep a job, maintain adequate self-care, or be successful in school. They consume significant time and they're at least intermittently recognized as irrational or excessive. Most people with OCD have both obsessions and compulsions.

Obsession vs. compulsion

The terms *obsession* and *compulsion* are often used interchangeably; however, they're quite different.

Obsessions are recurrent or persistent thoughts or mental images that are experienced as intrusive, unwanted, disturbing, shameful, or wrong. Obsessions cause significant anxiety or distress. People who have obsessions feel like they're being attacked by unbidden thoughts or images. An individual with such thoughts may wonder if he or she secretly wishes for this thing to happen or worry that he or she may end up causing it to happen.

Obsessions tend to fall into several predictable categories: dirt and contamination, order or symmetry, hoarding or saving, sexual thoughts or images, nonsensical doubts, religious obsessions, aggressive or violent images, and superstitious fears. People with OCD may have recurrent mental images with distressing content, seeing themselves smashing their baby's head on the floor, stabbing coworkers, having inappropriate sexual encounters, or inexplicably swerving into oncoming traffic while driving.

Compulsions are repetitive acts that are performed according to rigid rules and alleviate the anxiety caused by obsessions. In individuals with OCD, compulsions are usually linked to obsessions, although they can occur independently. When compulsions occur independently of obsessions, the need to perform them becomes its own source of anxiety, and the anxiety is alleviated by the compulsive behavior. It's important to note that compulsions don't "cure" obsessions. In fact, they cause the obsessions to become more ingrained and increase the discomfort and anxiety that they provoke.

The most prevalent compulsion involves washing. A person may have an unreasonable thought that a part of the body is dirty. Another common compulsion involves checking. This might consist of repeatedly checking that the door is locked or the coffee maker is turned off. It may also involve repeatedly checking on someone's safety; for example, that the person's child is safe in bed or still breathing. Many compulsions have to do with keeping someone else or one's self safe from harm. Other compulsions include repetitive routines, such as touching every fence post while walking; staring; blinking; or a need to perform a sequence of acts in succession.

In some cases, compulsions are logically related to the obsessions that drive them, such as with washing or checking compulsions. However, in many cases, the compulsive acts are random and have no possible effect on the feared thing. For example, a person who has an insistent thought that a loved one is going to die may develop a

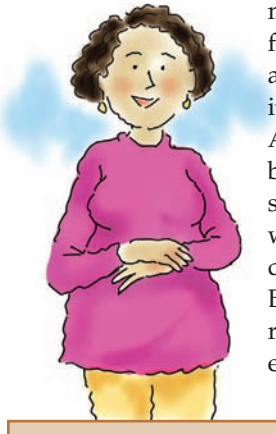
Caring for a patient with OCD

cheat sheet

- Support the patient in managing anxiety related to obsessions and inhibiting compulsive urges by helping him or her identify situations that increase anxiety and trigger obsessions and compulsions.
- Acknowledge the patient's anxiety responses and rituals or other compulsions without judging him or her.
- If the patient has compulsions that he or she needs to carry out, give the patient time to perform rituals without conveying disapproval.
- Gently encourage the patient to speak about the meaning and function of the behaviors.
- Carefully begin to limit the time devoted to the behaviors and offer positive reinforcement for the patient's successes in inhibiting urges to perform these behaviors.
- Help the patient identify how OCD may be adversely affecting important roles and relationships.
- Assist the patient with identifying strategies for improving relationships; enhancing the ability to complete tasks; and maintaining participation at work, school, or in other settings.
- Involve the patient's family or support network whenever possible.

ritualized routine consisting of entirely arbitrary actions, such as counting to 23 or pulling out a hair.

Although we describe compulsions as "acts" or "behaviors," mental acts can fall into this category. In fact, mental compulsions may be more common than overt behaviors such as washing, checking, or tapping. A mental compulsion is an internal act, such as forming a counter-image; mentally repeating a prayer, verse, or word; or mentally counting items in the environment or words on a page. A woman prone to seeing herself drop her baby may deliberately picture her child on a soft pillow (see *Pregnancy and OCD*). A person who has unwanted sexual thoughts may develop a compulsion to internally repeat a Bible verse. A student may be unable to read a page without counting the lines in each paragraph before proceeding.



Rumination may also be a mental compulsion. Psychiatrist Ian Osborn, MD, author of *Tormenting Thoughts and Secret Rituals: The Hidden Epidemic of Obsessive-Compulsive Disorder*, describes a young man with "unwanted musings" that unfold in a predictable way around a set of questions. While speaking with his girlfriend, this man would get carried away by thoughts about whether he was real and whether he and his girlfriend were actually there or not, and then question why he was posing such questions, and so on. The sequence of thoughts was both habitual and unstoppable, and the young man would think to himself: "Here come the thoughts."

Normal vs. abnormal

We all experience unbidden thoughts and see disturbing images before the mind's

Pregnancy and OCD

Pregnancy and childbirth are associated with the onset and exacerbation of OCD. During pregnancy, women experience changes in reproductive hormone levels (oxytocin, estrogen, and progesterone), as well as fluctuations in hormone levels. These changes are associated with changes in the transmission, reuptake, and binding of serotonin, which affects mood and is postulated to worsen OCD in some women and lead to onset of OCD in others. Stress associated with pregnancy, childbirth, and parenting is also associated with the onset and exacerbation of OCD.

Obsessions during pregnancy often involve thoughts about contamination, and compulsions often involve cleaning. Obsessions that appear following birth often involve disturbing images of harming the newborn child. New mothers may have intrusive thoughts or images of dropping or harming their children. These thoughts are extraordinarily distressing, and the new mother may find it very difficult to care for her child for fear that she'll unwittingly do what she's imagining. Such thoughts and distress contribute to the onset of depression in as many as 60% of women who experience them.

It's important to distinguish between postpartum OCD and postpartum psychosis. In the case of postpartum OCD, the mother knows that she shouldn't act on any of the images or thoughts she's experiencing. She's aware that these thoughts are irrational and she's likely to be very careful to avoid any situation in which the obsession is at risk for becoming reality. In the case of postpartum psychosis, the mother doesn't experience the images as aberrant. A woman with postpartum psychosis may feel that she ought to act on the delusions or visual or auditory hallucinations that she's experiencing, and that doing so is appropriate or unavoidable.

If you become aware that a new mother is experiencing thoughts or seeing images of harming her baby, it's important to gather more information. It's particularly important to assess for safety by asking questions about the mother's intention to act on her thoughts or any plans that she may have made. If these thoughts are associated with postpartum psychosis, there's risk that the mother may actually harm her child. You should also gather information about the mother's mood and her ability to care for her child, and about her support network.

It's very important to support the new mother, assess the risk that the mother may harm her child, and engage a support network. This includes informing appropriate medical providers, such as the mother's obstetrician/nurse-midwife or the child's pediatrician or pediatric nurse practitioner. You should alert family members or the mother's support network about the thoughts and how they may be affecting the mother's ability to care for her child. If OCD is diagnosed, support the mother in her new role and in identifying triggers for anxiety. Take steps to reassure the mother that she doesn't secretly wish to harm her child and ensure that the infant is receiving appropriate care.

eye. This is a normal human experience. An individual with OCD, however, can't turn the thought off or stop the image from recurring. Moreover, this person will give increasing attention to these thoughts or images, and spend increasing energy to avoid them. One way to describe an obsession is an inability of the brain to apply the brakes and change course. Current research on OCD describes it as a brain disorder that occurs when the brain overvalues thoughts and images, and can't inhibit them.

Routines and rituals are also a normal part of human experience. They have an important place in religious practice and daily life. We teach ourselves to go to sleep at night by repeating a routine set of steps, such as brushing our teeth, getting into pajamas, and reading in bed before lights out. Routines help us complete complex activities with accuracy and consistency. For example, when learning to drive, we practice a set of steps in a given order to make sure it's safe to change lanes. This increases our safety on the road. In the case of OCD, however, routine behaviors or mental compulsions don't serve any practical purpose, don't increase safety, and are debilitating or harmful.

Ego-syntonic vs. ego-dystonic

A key factor in identifying OCD is whether the recurrent thoughts or behaviors are *ego-syntonic* or *ego-dystonic.*

Ego-syntonic means something is embedded in our self-concept in a way that feels natural, even if causing distress. Importantly, an experience may be ego-syntonic even if others would label the experience delusional or psychotic. For example, a person with a paranoid delusion may believe that he or she is subject to a threat that others know to be false. The delusion is ego-syntonic because it's experienced by the individual as being consistent with his or her self-concept; it feels normal. This person will likely believe that others have a problem when they don't see the threat.

Alternatively, we consider something to be ***ego-dystonic*** if it seems inconsistent with our self-concept and feels foreign or repugnant. The obsessions and compulsions that define OCD are experienced as ego-dystonic either intermittently or all of the time. The person with obsessions and compulsions experiences these phenomena as unwanted, incorrect, or irrational. An individual with obsessions regarding germs or dirt knows that his or her hands aren't dirty, but can't banish the thought or the anxiety that it produces. Likewise, a person who has a persistent thought about stealing an item when at the grocery store is experiencing an ego-dystonic event. He or she has no desire to steal anything, yet continues to see him or herself doing it.

Obsessions and compulsions go against the grain of what the individual knows and feels to be sensible, right, natural, or normal. For this reason, they create shame and turmoil for the individuals who experience them. It's important to note, however, that people with very severe OCD may lose the ability to see their obsessions or compulsions as unnatural or inappropriate. They may become convinced that their obsessions or compulsions are simply true. A diagnosis of OCD requires that the individual has recognized the obsessions or compulsions as unreasonable or excessive at some point, but may not recognize them as such all of the time or even most of the time.

Treatment: Therapy and medication

The gold standard for treatment of OCD is behavior therapy. Studies suggest that behavior therapy is beneficial in about 80% of cases. Behavior therapy works to extinguish the anxiety associated with obsessions by gradual exposure to the obsession without performing the compulsive act that has become the individual's habitual response. Behavior therapy relies on the premise that the compulsive act worsens anxiety in the long term. The compulsion reinforces

the fearfulness of the obsession through the mechanism of avoidance.

Behavior therapy generally starts with a record of the frequency, intensity, and duration of obsessions and compulsions. The individual ranks the obsessions and compulsions from most to least distressing or debilitating, and a decision is made about targets for therapy.

Work begins with imagining the selected feared stimuli while resisting the urge to avoid it by performing the compulsion. For example, a person with an obsessive thought that he or she will contract an illness from germs in the environment may begin therapy by picturing himself or herself touching various objects that may have germs while simultaneously resisting the urge to wash his or her hands.

As therapy proceeds, the individual will expose him or herself more fully to the feared stimulus and resist the compulsion that functions as the avoidance behavior. This reduces the physiologic fear response that occurs with exposure to the stimulus. Over time, the response is extinguished and the cycle is broken.

Medications can also be useful in treating OCD; however, their efficacy is less than that of behavior therapy. Medication therapy has been shown to help 50% to 70% of individuals treated. Medication used in conjunction with behavior therapy can help individuals reduce the intensity of their obsessions, together with the intensity of their urges to perform compulsive acts. This allows for breathing space to begin behavior therapy.

The first-line medication therapies for OCD are antidepressant medications, including selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), and tricyclic antidepressants (TCAs). These medications increase the availability of the neurotransmitter serotonin, or the availability of serotonin and norepinephrine, for binding in the brain. Increased availability of serotonin and norepinephrine has been associated with reductions in anxiety and depression. The FDA has approved the SSRIs fluoxetine, paroxetine, and sertraline; the SNRI fluvoxamine; and the TCA clomipramine for the treatment of OCD.

Monoamine oxidase inhibitors (MAOIs) also increase the availability of serotonin and norepinephrine, and may be used to treat OCD in individuals who don't respond to other medication therapies. These medications have significant drug-drug

On the web

- **American Psychiatric Association:** http://www.psychiatry.org/obsessive-compulsive-disorder
- **Anxiety and Depression Association of America:** http://www.adaa.org/understanding-anxiety/obsessive-compulsive-disorder-ocd
- **International OCD Foundation:** http://www.ocfoundation.org/index.aspx
- **KidsHealth.org:** http://kidshealth.org/teen/your_mind/mental_health/ocd.html
- **National Alliance on Mental Illness:** http://www.nami.org/Template.cfm?Section=By_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=142546
- **National Institute of Mental Health:** http://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd/index.shtml

and drug-food interactions, and aren't considered first-line therapies for this reason.

When medications are used to treat OCD, they're generally dosed at the upper end of the therapeutic range. Augmentation of an SSRI or SNRI with an antipsychotic medication or a benzodiazepine may be useful in treating refractory OCD; however, these medications don't carry FDA approval for treatment of OCD.

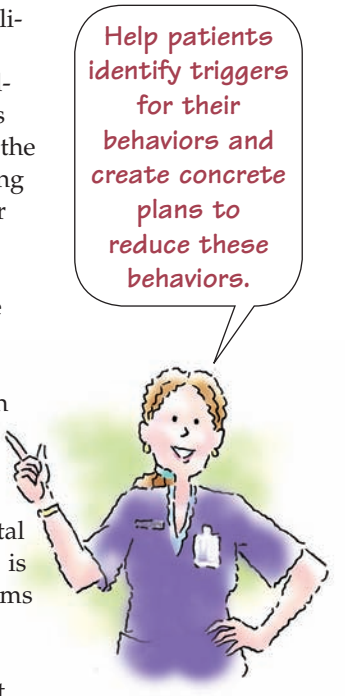
Nursing considerations

Nurses play an important role in caring for a patient with OCD. In most cases, care is sought when the condition has begun to exact a high toll on the patient's ability to function on a daily basis. He or she is likely experiencing difficulty maintaining family stability or performing adequately at work or school. You can support the patient in managing anxiety related to obsessions and inhibiting compulsive urges. This includes helping the patient identify situations that increase anxiety and trigger obsessions and compulsions, as well as identifying how the disorder may be adversely affecting important roles and relationships.

It's important to acknowledge the patient's anxiety responses and rituals or other compulsions without judging him or her. In almost all cases, a person with OCD will have a great deal of shame about his or her obsessions or compulsions. If the patient has compulsions that he or she needs to carry out during contact with you—for example, during an office visit or while in an acute care setting—it's important to give the patient time to perform rituals without conveying disapproval.

Gently encourage the patient to speak about the meaning and function of the behaviors. Over time and in collaboration with the patient, you can carefully begin to limit the time devoted to the behaviors and offer positive reinforcement for the patient's successes in inhibiting urges to perform these behaviors.

When important roles and responsibilities have been adversely affected by the patient's OCD, help him or her acknowledge this impact and identify strategies for improving relationships; enhancing the ability to complete tasks; and maintaining participation at work, school, or in other settings. Involve the patient's family or support network whenever possible. In many cases, the patient is likely to have become isolated, he or she may be less able to access support networks, and supportive relationships may have been stressed by the disorder.



Coping with OCD

OCD is a serious and debilitating mental disorder. Without treatment, its course is unremitting and chronic. OCD symptoms are often experienced as embarrassing and shameful, and individuals may go to great lengths to hide them. An adult diagnosis of OCD is made on the basis of obsessions and/or compulsions that have been recognized at some point by the individual experiencing them as excessive or unreasonable. These obsessions and/or compulsions cause distress, are time-consuming, and substantially interfere with important daily functions or relationships. In children, OCD may be diagnosed even if the child doesn't recognize the obsession or compulsion as excessive or unreasonable. The most effective treatment for OCD is behavior therapy; however, medications may be used independently of or together with behavior therapy.

Nurses play an important role in supporting patients and providing reassurance that they can make progress in treatment. You can help patients identify triggers for their behaviors and create concrete plans to reduce these behaviors. Nurses also play a vital role in helping patients maintain support networks and repair relationships that may have been adversely affected by OCD. ■

Learn more about it

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