OBSESSIVE AND COMPULSIVE DISORDER : CAUSE AND TREATMENT

SWARUP CHANDI
M.A. in EDUCATION
Department of Education
West Bengal State University, Barasat, N 24 Pgs, West Bengal.

Abstract: ***This study also focused to identify the cause and treatment of OCD. Obsession are related with repetative thought and Compulsion are related to repetative action. Here throughly discussed how to identify OCD affected person and how to deal with this person.***

Keywords: ***OCD , DSM-IV, NICE , CBT, CMHT***.

I. OBJECTIVES OF THE STUDY

The present study is an attempt to fulfil the following objectives-

1. To illustrate the concept of Mental disorder.
2. To discuss the different types of mental disorder.
3. To discuss the concept of OCD.
4. To show the Identification strategy of OCD affaired person.
5. To discuss the Cause & Treatment of OCD.

II. INTRODUCTION

Ritualistic behaviors are common to the human experience. These behaviors allow individuals in the same group to establish complex communication with each other, which facilitates and standardizes their relationships. In fact, rituals express a neuronal organization that improves behaviors and that has been developed for the selection of species. To some extent, we use rituals to. Relieve the brain system,. for instance, when taking a shower, we always apply soap to a certain part of the body first and then to another part, etc, thus .opening. our mind to other thoughts. Or, when we get home and leave objects, such as wallet or documents, always in the same place. These schemes, routines or rituals rely upon certain brain circuits. Interestingly enough, some of these rituals co-occur with superstitions, showing the cognitive aspect of thoughts, which are no longer just a repetitive behavior. Therefore, rituals and superstitions are considered a normal part of child development. For example, preschool children create rituals, especially of bedtime, mealtime, and bath time. These repetitive behaviors are more frequent between the ages of two and four years. In school-aged children, rituals involve games with strict and extensively discussed and negotiated rules, which frequently take longer than the game itself. At this age, children also start collecting different objects, which is a current version of storing rituals. Superstitious behaviors may involve bad luck or good luck. Children aged between two and six years have superstitions that are filled with fantasy . a

characteristic of pre-logical or magical thinking. After acquiring logical or concrete thinking, children tend to change their superstitious behaviors, channeling them towards aspects of their own performance. In some individuals, these behaviors get out of control, and they begin to show repetitive behaviors without any functionality, which are detrimental to their adaptive capacity. These events are known as obsessivecompulsive disorders (OCD). It is essential that we know when children.s behaviors are no longer adaptive and become dysfunctional and pathological, requiring treatment. Usually, ordinary rituals help individuals to establish a relationship with the surrounding environment and also help them to control anxiety in times of difficulties, often giving them

III. CONCEPT OF MENTAL DISORDER

The DSM-IV-TR defines mental disorders as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (p. xxxi).

Diagnostic and Statistical Manual of Mental Disorders, the term *mental disorder* unfortunately implies a distinction between "mental" disorders and "physical" disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much "physical" in "mental" disorders and much "mental" in "physical" disorders. The problem raised by the term "mental" disorders has been much clearer than its solution, and, unfortunately, the term persists in the titl of DSM-IV because we have not found an appropriate substitute.

The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction—for example, structural pathology (e.g., ulcerative colitis), symptom presentation (e.g., migraine), deviance from a physiological norm (e.g., hypertension), and etiology (e.g., pneumococcal pneumonia). Mental disorders have also been defined by a variety of concepts (e.g., distress, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation). Each is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions.

In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress

(e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

IV. CLASSIFICATION OF MENTAL DISORDER

DSM-IV is a categorical classification that divides mental disorders into types based on criteria sets with defining features. This naming of categories is the traditional method of organizing and transmitting information in everyday life and has been the fundamental approach used in all systems of medical diagnosis. A categorical approach to classification works best when all members of a diagnostic class are homogeneous, when there are clear boundaries between classes, and when the different classes are mutually exclusive.

In DSM-IV, there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder.

It was suggested that the DSM-IV Classification be organized following a dimensional model rather than the categorical model used in DSM-III-R.

Although dimensional systems increase reliability and communicate more clinical information (because they report clinical attributes that might be subthreshold in a categorical system), they also have serious limitations and thus far have been less useful than categorical systems in clinical practice and in stimulating research.

A multiaxial system involves an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome. There are five axes included in the DSM-IV multiaxial classification:

4.1 Axis I Clinical Disorders Other Conditions That May Be a Focus of Clinical Attention.

4.2 Axis II Personality Disorders & Mental Retardation.

4.3 Axis III General Medical Conditions.

4.4 Axis IV Psychosocial and Environmental Problems.

4.5 Axis V Global Assessment of Functioning.

The use of the multiaxial system facilitates comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psychosocial and environmental problems, and level of functioning that might be overlooked if the focus were on assessing a single presenting problem. A multiaxial system provides a convenient format for organizing and communicating clinical information, for capturing the complexity of clinical situations, and for describing the heterogeneity of individuals presenting

with the same diagnosis. In addition, the multiaxial system promotes the application of the biopsychosocial model in clinical, educational, and research settings.

However here briefly disscuss on Obsessive Compulsive Disorder which fall on DSM-IV, Axis-II.

V. OBSESSIVE COMPULSIVE DISORDER

We all have habits and routines that help us stay clean, healthy, and safe. We wash our hands before eating. We lock the doors and turn off the oven before leaving the house. And we may hum a favorite song while working, read before bedtime, or lay out our clothes for the next day as comforting rituals.

But people with obsessive-compulsive disorder, or OCD, experience unwanted and intrusive thoughts (obsessions), which cause them to repeatedly perform ritualistic behaviors and routines (compulsions) to ease their anxiety. Some spend hours at a time performing complicated rituals involving hand washing, counting, or checking to ward off persistent unwelcome thoughts, feelings, or images. Others live in terror that they will accidentally harm someone, blurt out an improper statement, throw out something by mistake, or do something else wrong. They realize that their seemingly uncontrollable behavior is irrational, but they feel unable to stop it.

The American Psychiatric Association includes obsessive-compulsive and related disorders, including body dysmorphic disorder, hoarding, trichotillomania (hair-pulling), and skin-picking together in a category that is closely linked to anxiety disorders.

The category of anxiety disorders includes generalized anxiety disorder (GAD), panic disorder, social anxiety disorder, selective mutism, separation anxiety, specific phobias, agoraphobia, and substance/medication-induced anxiety disorder. These are characterized by persistent, irrational, or overwhelming anxiety that interferes with daily activities. Evidence shows that these disorders share some symptoms and can occur at the same time.

ICD-10 define as OCD “Obsessional thoughts are ideas, images or impulses that are repetitive, stereotypical and usually distressing. Patients recognise them as their own thoughts, but they are involuntary, often repugnant, and the patient often tries to resist them”.

“Compulsive acts are repetitive, stereotypical behaviours that the patient does not find pleasurable. Their function is to prevent some objectively unlikely event, yet the patient recognises the behaviour as pointless or ineffectual. Repeated attempts to resist invariably leads to anxiety”.

5.1 OBSESSIONS:

Obsessions are unwelcome thoughts, images, urges or doubts that repeatedly appear in your mind; for example, thinking that you have been contaminated by dirt and germs, or experiencing a sudden urge to hurt someone.

These obsessions are often frightening or seem so horrible that you can't share them with others. The obsession interrupts your other thoughts and makes you feel very anxious.

"I get unwanted thoughts all through the day, which is very distressing and affects my ability to interact with others and concentrate on my studies and work".

5.2 COMPULSIONS:

Compulsions are repetitive activities that you feel you have to do. This could be something like repeatedly checking a door to make sure it is locked or repeating a specific phrase in your head to prevent harm coming to a loved one.

The aim of a compulsion is to try and deal with the distress caused by the obsessive thoughts and relieve the anxiety you are feeling. However, the process of repeating these compulsions is often distressing and any relief you feel is often short-lived.

"Getting ready for each day involves so much hand washing, mental rituals, and doing things in the same order everyday... Sometimes, I feel like staying in bed and avoiding the day".

VI. THE OCD CYCLE

The diagram below shows how obsessions and compulsions are connected in an OCD cycle.

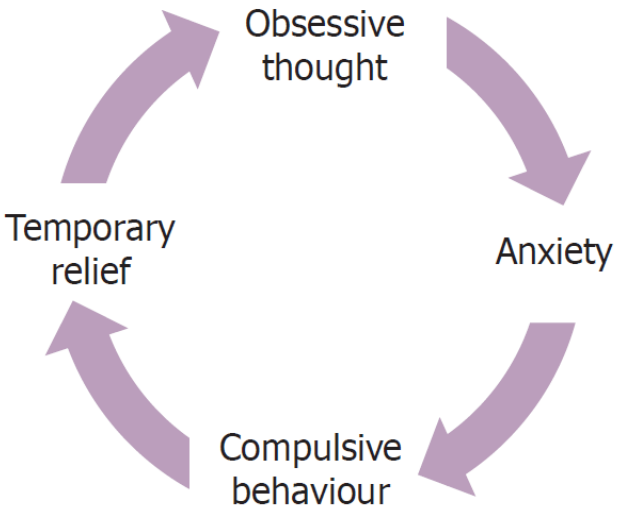

Figure -1: OCD Cycle

VII. HOW CAN OCD AFFECT OUR LIFE

Obsessions and rituals can interfere substantially with a regular routine of schoolwork, job, family, or social activities. Several hours each day may be spent on obsessive thoughts and performing seemingly senseless rituals, making concentrating on daily activities very difficult. People with OCD may go to great lengths to hide their behavior, even from friends and loved ones. Left untreated, OCD may follow a progressive course that can become disabling.

VIII. IDENTIFICATION STRATEGY OF OCD AFFAIRED PUPIL

Various characteristics or dimensions of Obsession & Compulsion are present here partly. Which is help you to identified OCD affaired person.

8.1 CRITERIA OF OBSESSION:

- Constant, irrational worry about dirt, germs, or contamination.
- Excessive concern with order, arrangement, or symmetry.
- Fear that negative or blasphemous thoughts or impulses will cause personal harm or harm to a loved one.
- Preoccupation with losing or throwing away objects with little or no value distasteful religious and sexual thoughts or images.

8.2 CRITERIA OF COMPULSION:

- Cleaning – Repeatedly washing hands, bathing, or cleaning household items.
- Checking – Checking and re-checking several to hundreds of times a day that the doors are locked, stove is turned off, hairdryer is unplugged, etc.
- Repeating – Unable to stop repeating a name, phrase, or activity.
- Touching and arranging.
- Hoarding – Difficulty discarding useless items such as old newspapers or magazines, bottle caps, or rubber bands.
- Mental rituals – Endless reviewing of conversations, counting, or praying to neutralize obsessions.

IX. CAUSES OF OCD

1. OCD is a disorder of the brain specifically regions associated with suppressing responses and habits.. It appears to run in families, and genetics may play a partial role in its development. Scientists continue to

study the life stressors, triggers, and factors that are important to the development and severity of symptoms, including whether they begin in childhood or later in life.

2. Early life experiences (Rachman & Hodgson, 1980) found that excessively harsh punishment for making mistakes may predispose individuals to develop **obsessive doubts** and **checking rituals.**
3. It could also be that one or both of our parents may have had similar anxiety and shown similar kinds of behaviour (such as obsessional washing), and we learned to use this type of behaviour as a coping technique.
4. Some experts have noted that some children seem to develop OCD symptoms very suddenly after having a streptococcal (or strep) infection, such as strep throat or scarlet fever. However, it is currently not known why this might occur and no research has yet been able to identify a physical cause to explain the link.
5. Children and adolescents can develop symptoms of OCD, which are real and not a result of a particular event, phase, or anything that the child or parent did wrong. Children often involve their family in their compulsions, which may also cause great strain in family relationships and should be addressed in therapy. Early diagnosis and intervention is critical for recovery, and it can also help lessen the strains and impact of the disorder on development.
6. Symptoms typically begin in late adolescence, by age 14 for about one-fourth of children. Boys experience symptoms earlier than girls, about 25 percent before age 10. Some experts argue that symptoms beginning in childhood may predict a more severe or chronic course, as well as a higher incidence of tic disorders, anxiety disorders, attention-deficit hyperactivity disorder (ADHD), and eating disorders, and other related disorders.
7. Children with OCD, anxiety, or depression may also be less able to verbalize their discomfort and be prone to headaches, stomachaches, and other stress-related physical ailments. Symptoms may make it difficult for a child to complete schoolwork, household chores, and other tasks. Relationships with peers, siblings, and parents may become problematic.
8. The most common obsessions of children focus on a fear of contamination or illness, fear of harm to others and self, need for symmetry or feeling “just right,” and excessive doubt.
9. Mental health provides can more easily diagnose childhood compulsions because they are easier to observe than obsessions. Typical compulsions of children include cleaning or washing, checking, and performing arranging or organizing rituals. Children often have difficulty reporting their obsessions, which a mental health provider is required to assess.
10. Children might not understand that their obsessions and compulsions are irrational or they might not be able to explain their symptoms. Some might be wary of talking about symptoms that frighten them, or they feel shame about the thoughts involved in their obsessions.

11. A triad of OCD, tic disorder, and ADHD has been described in children, as has OCD occurring in Tourette's syndrome. Acute development of symptoms might occur, which could be related to infectious agents, post-infectious autoimmune syndromes, or other environmental factors.

X. TREATMENT OF OCD

Before you have any treatment, your doctor should discuss all your treatment options with you, and your views and wishes should be taken into account.

1. NICE's 'stepped' model

If you access help on the NHS, your treatment should be in line with NICE (National Institute for Health and Care Excellence) guidelines. NICE recommends 'stepped' treatment for OCD. This means that you should receive different types of treatment depending on how severe your symptoms are and how you responded to any previous treatment.

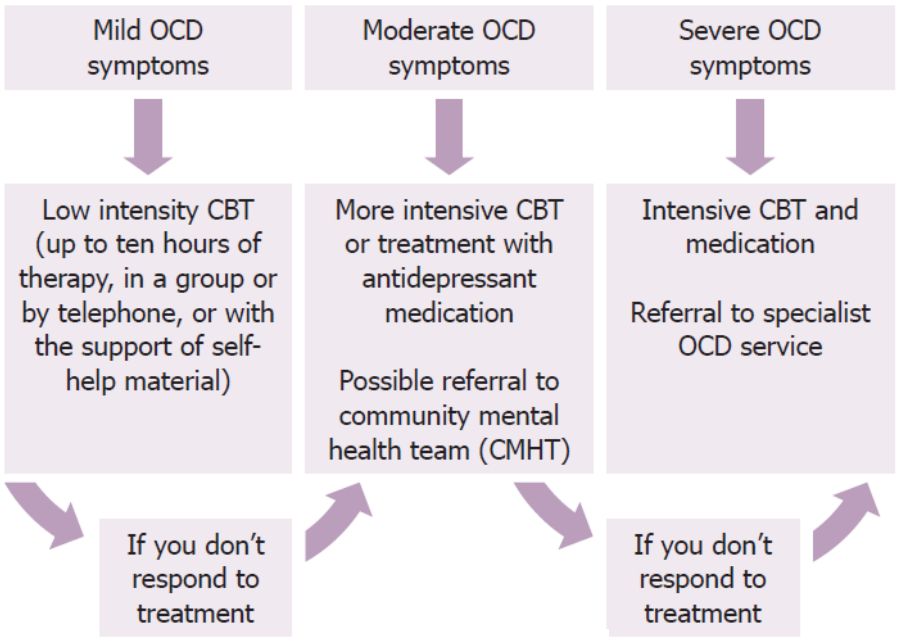

Figure – 2: NICE model

However, the treatments recommended in the NICE guidelines are not appropriate for everyone. There are a number of options available to treat OCD and different things work for different people. You may find that a combination of approaches is most helpful for you, and different approaches may help you at different times.

2. COGNITIVE BEHAVIOUR THERAPY (CBT)

"CBT techniques helped me to see the intrusive thoughts for what they are, and put them in their place".

Cognitive behaviour therapy (CBT) is a talking treatment which aims to identify connections between your thoughts, feelings and behaviour. It aims to help you develop practical skills to manage any negative

patterns of thinking or behaviour that may be causing you difficulties. It can be done one-to-one, or in a group. There is considerable evidence to suggest that this therapy is especially effective in dealing with OCD.

The behavioural element (also known as Exposure Response Prevention – ERP) is strongly recommended for treating OCD. ERP works by helping you to confront your obsessions and resist the urge to carry out compulsions. The aim is to help you feel less anxious about obsessive thoughts over time, and make you less likely to engage in compulsive behaviour. For example, if you fear that you will harm someone and avoid sharp objects as a result, you might build up to a therapy session where you hold a knife while sitting in a room with other people.

This technique needs to be carefully managed to avoid causing distress and anxiety, so it is important that you understand the treatment fully and feel comfortable with your therapist. "It's hugely frustrating and exhausting trying to break out of patterns that you know aren't helpful or healthy. It can feel hopeless. But by challenging the behaviours, thoughts or compulsion you can eventually achieve fresh change that seemed impossible".

You are entitled to receive free CBT on the NHS, and your GP should be able to refer you to a local practitioner. However, waiting times for talking treatments on the NHS can be long. If you feel that you don't want to wait or that you would like more support than is being offered, you may choose to see a therapist privately. The British Association for Behavioural and Cognitive Psychotherapies maintains a register of accredited CBT therapists.

3. MEDICATION

Some people find drug treatment helpful for OCD, either alone or combined with talking treatments, such as cognitive behaviour therapy (CBT).

"I've been on meds for the last three years and my OCD is so much more controllable".

Before taking any medication, it is important to read the patient information leaflet (that comes with the medicine) and discuss possible benefits and side effects with your doctor.

4. ANTIDEPRESSANTS

The drugs prescribed most commonly are SSRI antidepressants, such as fluoxetine (Prozac), fluvoxamine (Faverin), paroxetine (Seroxat), citalopram (Cipramil) and sertraline (Lustral). These drugs are all recommended by NICE for the treatment of OCD. These drugs may have side effects, including nausea, headache, sleep disturbance, gastric upsets and increased anxiety. They may also cause sexual problems.

The tricyclic antidepressant clomipramine (Anafranil) is also licensed for the treatment of obsessional states in adults. This should normally only be prescribed if an SSRI antidepressant has already been tried and not

been effective. The side effects of clomipramine can include a dry mouth, blurred vision, constipation, drowsiness and dizziness.

5. TRANQUILISERS

If you are experiencing very severe anxiety as a result of OCD, you may be offered tranquillising drugs, such as diazepam (Valium). This type of medication should only be used for short periods of treatment because of the risk of addiction. The side effects of tranquilisers can include drowsiness, confusion, unsteadiness and nausea.

6. BETA-BLOCKERS

Beta-blockers are occasionally given to people to treat the immediate symptoms of severe anxiety. They don't treat the anxiety itself, but act on the heart and blood pressure to reduce physical symptoms, such as palpitations. The beta-blocker most commonly used for anxiety is propranolol (Inderal). The main side effects include a slow heartbeat, diarrhoea and nausea, cold fingers, tiredness and sleep problems.

7. NEUROSURGERY FOR MENTAL DISORDER

Neurosurgery (previously known as psychosurgery) is surgery on the brain. It is not recommended for treating OCD, but is very occasionally offered in severe cases, when other treatments have been unsuccessful. Neurosurgery is strictly regulated under the Mental Health Act, and can't be given without consent.

8. COMMUNITY MENTAL HEALTH AND SOCIAL CARE

If your OCD is severe or complex, your GP may refer you to a community mental health team (CMHT). A CMHT is usually made up of range of professionals, such as psychiatrists, psychologists, social workers and occupational therapists. The team can offer medication, basic counselling or other mental health treatments like cognitive behaviour therapy (CBT). They should also be able to help with you with wider issues you have as a result of your OCD, such as difficulties around housing, benefits or everyday living.

Even if you are not referred to a CMHT, or if you feel you are not receiving the support you need, you may be entitled to have a social care assessment to see if you are eligible for social care support.

9. SPECIALIST OCD SERVICES

If you require more intensive support, it is recommended that you are referred to a specialist OCD service in your area. However, in reality, access to specialist services across the country is patchy and you may need to travel outside your local area.

10. SELF-HELP MATERIALS

Some people use self-help books, computer programmes or websites to help manage their OCD. Many self-help materials are based on cognitive behaviour therapy (CBT) principles , which have been shown to be particularly effective in treating OCD. OCD UK has a list of popular selfhelp books on their website, and there are several computerised CBT programmes available for free or via prescription from your GP.

There are many self-help resources available, and you may have to try a few before finding one that is right for you. You may decide to use materials alongside professional help, or you may use them to develop your own coping strategies.

11. PEER SUPPORT GROUPS

A self-help, or peer support group, offers an opportunity to meet up with people who have gone through the same sort of experiences as you. It can help you feel less isolated and give you and other group members a chance to share how you cope with your feelings and experiences. You can also access peer support groups online, through forums, social media sites or online communities. While online peer support can be extremely helpful, it's important to remember that you don't always know who you're talking to, so you should think carefully about what information you want to share.

You can find details of support groups and online peer support on the OCD UK and OCD Action websites.

12. RELAXATION AND MINDFULNESS TECHNIQUES

Learning a relaxation technique won't help you resolve obsessive thoughts or compulsions, but it may help you deal with anxiety that you experience as a result of your OCD. Relaxation techniques can teach you:

• how to improve your breathing to reduce tension

• physical exercises that relax your muscles

• action plans to help you progress from coping with non-stressful situations to those that you find difficult.

For local relaxation classes, search the internet, or contact your local library or GP.

Some people may also find mindfulness techniques helpful to manage unwanted or intrusive thoughts and reduce anxiety. Mindfulness is a way of paying attention to the present moment, using techniques like meditation, breathing exercises and yoga. Be Mindful has details of local mindfulness classes around the UK.

13. PHYSICAL ACTIVITY

Doing some regular physical activity, whether it is going for a short walk or playing a team sport, can help improve your mental wellbeing – particularly if you do it outside. Exercise releases feel-good hormones and doing something active can distract you from unwanted thoughts.

XI. CONCLUSION

The prevalence of people diagnosed with OCD is increasing. It is important to help these individuals by providing them with effective treatments and helping them overcome the barriers that they face in their everyday life. This study also help to Psychotherapist , Parents and Community members to deal OCD affected person.

XII. ACKNOWLEDGMENT

I am grateful to *Prof:*Abhijit Kumar Pal , Dr. Madan Mohon Chale , Dr. Sankar Kar , Partha Roy, Ambika Gain , Balaram Das, who inspired and directs me to carryout this paper.

REFERENCES

[1] Marcos T. Mercadante et. al.(2004). The neurobiological bases of obsessive compulsive disorder and Tourette syndrome. *Jornal de Pediatria* - Vol. 80, No.2(Suppl), pp S35-S44

[2] http://ddceutkal.ac.in/Syllabus/MA_Education/Paper-3.pdf retrieved at 27-05-18 09:56

[3] http://bcs.worthpublishers.com/WebPub/Psychology/comerabpsych8e/IRM/COMER%20IR%20B1-B84.pdf retrieved at 07-05-18 07:28

[4] https://wps.prenhall.com/wps/media/objects/219/225111/CD_DSMIV.pdf retrieved at 17-09-18 05:32

[5] https://justines2010blog.files.wordpress.com/2011/03/dsm-iv.pdf retrieved at 18-05-18 09:38

[6] https://adaa.org/sites/default/files/OCD_adaa%20rev%20506.pdf retrieved at 20-07-18 10:45

[7] https://www.mentalhealth.org.nz/assets/A-Z/Downloads/Understanding-OCD-MIND-UK-2013.pdf retrieved at 19-11-18 08:51