

## CHAPTER I

# What You Need to Know to Help Yourself

Until recently, obsessive-compulsive disorder (OCD) was considered rare. Now we know that millions have the problem, and there are two scientifically proven treatments for it—behavior therapy and medications. Though OCD can be a devastating disorder, treatment can enable 75 percent of sufferers to significantly reduce or eliminate their symptoms.

On the surface, OCD appears to be senseless, capricious, unpredictable, and uncontrollable. But beneath this façade exists a system that operates with consistency and predictability and, consequently, is subject to control. It is controlling this disorder that is the object of our work. In this book, you will learn how to use behavior therapy to relieve your suffering and have a normal life.

Client education is important in the treatment of many health problems, and it is a critical requirement in the treatment of OCD. This is because *you* are the only one who can eliminate your symptoms. You are your primary therapist and, as such, you must have a

comprehensive knowledge of your disorder. This chapter will educate you about the disorder. You will learn what is known about its cause and the specific conditions that are necessary for a formal diagnosis. I'll provide definitions of what obsessions and compulsions are and review some common examples. You'll also be introduced to some other mental and physical activities that can be mistaken for obsessions and compulsions. The chapter ends with a discussion of additional problems generated by OCD, its frequency in the general population, and the path it takes over time, with and without treatment.

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## A DISORDER OF FEAR

OCD is a disorder of fear—fear of the improbable and the impossible. This book is about one particular type of OCD where washing compulsions are used in futile attempts to offset obsessive fears of being contaminated. These obsessions occur when someone fears they have made contact with substances that are potentially harmful, such as germs, dirt, chemicals, radiation, environmental contaminants, and so forth. This contact activates fear and dread of the possibility of contracting illnesses or fatal diseases. To offset the immediate anxiety and prevent future dreaded outcomes, the person engages in ritualistic washing. This provides some temporary relief but no escape from the grip of endless cycles of contamination obsessions and washing rituals, as Betty's case illustrates.

### ■ Betty's Fear of Bodily Secretions

Betty, a thirty-two-year-old professional, had managed to successfully graduate high school and complete college, despite having mild to moderate bouts of OCD since childhood. When I started working with her, she had been successfully employed for several years by a large national corporation. However, two years prior to her first visit with me, her obsessive fears intensified. This coincided with her engagement and marriage soon thereafter. She was no longer living alone. This meant she had to reveal her OCD to

her husband, Juan, who at first accepted her rituals and avoidances. As time passed her symptoms worsened, and his tolerance for them waned. He urged her to seek treatment, and realizing that her symptoms were getting worse and interfering with their relationship, she did.

Betty had obsessions of being contaminated by urine, blood, and feces. She worried that microscopic particles of one or more of these substances could be on anything that other people touched, which essentially meant just about everything outside her home. Even at home she had problems with things her husband touched if he didn't immediately wash his hands on entering the house. If she touched—or thought she touched—a “contaminated” object or person, she became extremely anxious, feared she would contract AIDS, and washed as soon as possible. When she was clean she knew these fears were ridiculous, but when “contaminated,” they seemed real. Frequently she washed “just in case,” and estimated washing her hands twenty-five times a day or more.

Washing was always the result of a failure to keep a safe distance from sources she perceived as being contaminated. For example, she wouldn't come within two feet of public waste disposal containers, no matter how elegantly they were designed. Even then she worried about accidental contacts that she hadn't realized at the time, and the uncertainty triggered washing. She diligently tried to avoid touching anything other people touched—from doorknobs to elevator buttons—by asking other people, in public, to open doors or press elevator buttons for her. If nobody was available, she used tissues.

Betty's avoidance behaviors and washing rituals were only partially successful, because she always felt contaminated to some degree outside her home. Nevertheless, she generally managed to complete her day's work. But on those occasions when she touched something that was particularly frightening and washing or using antibacterial hand wipes was mandatory, she was prepared. A stash of wipes was always kept handy. She partially solved the

problem of using public toilets by urinating and having bowel movements only at home. Withholding urine for periods of ten to twelve hours or more was an outcome of this practice. Consequently, she had frequent urinary tract infections. Sometimes the pressure to void was greater than her capacity to hold it, and Betty used public toilets by combining the skills of a contortionist and an Olympic gymnast.

Her sanitary sanctuary was her home. And on arriving there, she immediately undressed, put the clothes in the washer, urinated, showered (for 30 minutes or more), and then put on garments worn only in the house. (Betty had tried to get her husband to practice her “decontamination” procedures when he got home, but he refused.) Besides decontaminating herself, she also decontaminated many of the items they brought home. This meant lots of washing of new items before they were used (including new clothes before they were worn), household items, and such. Certain things were impossible to sanitize, so she placed them together in an area set aside for dirty items. When she had to use them, she washed before touching anything else. There were even pieces of furniture she wouldn’t sit on, because in her mind they were sources of disease. Recall that for years she lived alone and, over time, developed patterns of avoidance behavior that were practiced daily. So it was predictable that she would try to impose the same patterns of avoidance on her husband. But, similar to his refusal to follow her decontamination practices on entering the house, he refused to comply with her demands to wash his hands before touching this object, sitting in that chair, or using anything that he wanted to use. This was fortunate, because neither of them realized then that joining her in practicing rituals and avoidance would have worsened her symptoms.

However, like most people with OCD, she wanted repeated reassurance that her fears about contamination and illness would not come true. She would constantly ask questions like, “Is this clean? Did you wash your hands? Did I touch that? Did that touch me?” Juan gave her

reassurance thinking that he was easing Betty's distress, but ironically the reassurance was harmful. It contributed to the continuation of her symptoms just as it does in all cases of OCD. You'll get a full explanation of how reassurance prevents recovery and how it can be eliminated in chapter 8.

Betty was depressed. Her efforts to cope with her OCD were not working. She became increasingly preoccupied with the fear of being contaminated, which increased the frequency and duration of hand washing, clothes washing, and cleaning of household items. Her conversations with Juan revolved around OCD more than any other topic. At work, intrusive thoughts interfered with her concentration. She felt hopeless.

At this point Betty started behavior therapy and her depression lifted as a result of the elimination of her contamination fears. In addition, there was no further need for compulsive washing and cleaning. This gave her more time and energy to do other things, including engaging in activities and interests with her husband, which strengthened their relationship. She also modified her lifestyle to reduce the possible return of the symptoms. The details of her treatment and methods for preventing relapse will be discussed later.

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## BEHAVIOR THERAPY, THE TREATMENT OF CHOICE

Referred to as a disorder, OCD is anything but disorderly. The obsessions can be about a variety of thoughts, images, or impulses, and the compulsions can involve any number of repeated actions or thinking patterns. What is most important, however, is not how they look, but how they work. And they always work together, in the same way, in everyone. People have inevitable cycles of irrational fears (*obsessions*) that compel repetitive actions, both mental and physical (*compulsions*, also referred to as *rituals*), which bring relief (See figure 1).

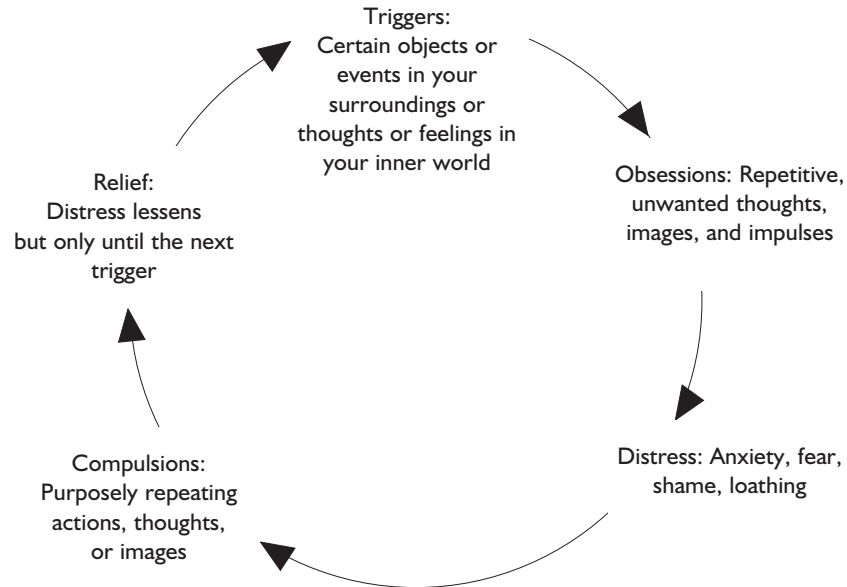


Figure 1: The Obsession-Compulsion Cycle

But this relief lasts only until the onslaught of more irrational fears. This can be a frustrating, vicious cycle, but it's the understanding of this dynamic that enables us to tame the OCD monster. Here's how it works.

## The Dynamic

People with OCD develop excessive fears of situations that are not truly dangerous. For example, Betty worried that contact with things that other people touched would contaminate her with microscopic specks of blood that would cause her to develop AIDS. This triggered immediate anxiety and the dread of eventually being HIV-positive. This, in turn, triggered fears of a long period of gruesome illness and ultimately death. These irrational thoughts, which were sometimes accompanied by mental images, were her obsessions. To terminate the immediate anxiety and prevent the long-term dreaded

consequences, she washed and cleaned excessively. These behaviors were her compulsions. Once this cycle of obsessions and compulsions is established, it is self-perpetuating and tends to worsen over time.

## Taming the OCD Monster

The powerful behavior therapy technique called *exposure and response/ritual prevention* (E&RP), developed by Victor Meyer (1966), breaks this malignant cycle. It eliminates or reduces your obsessions by *desensitizing* you to the fears they provoke. Simply put, the exposure and ritual prevention teaches you to do the opposite of what you have been doing. Instead of avoiding situations that trigger fear, you must expose yourself to them. And instead of engaging in compulsions, you must prevent them. In this way, you will *habituate* to the fear, that is, you simply get used to it. Exposure and response prevention is not as scary as it sounds. To the contrary, it's rewarding, because as you feel the fear gradually falling it tells you that the treatment is working. Also, the exposures are done gradually, which keeps the distress levels in the mild to moderate range.

Once the obsessions have been eliminated, there is, obviously, no need for compulsions. So, to be free of compulsive washing, our first objective will be to free you of the obsessions that trigger washing. You'll learn how to do this in the following chapters.

This kind of exposure therapy works because it relies on the natural ability of the brain to stop responding to thoughts, images, or impulses that are not actually dangerous, which is true of all obsessions. The only requirements are that obsessions be deliberately triggered and the resulting fear not turned off by compulsions. Because the thoughts, images, and impulses are not dangerous, no harm occurs, and the false alarm that the brain previously gave is turned off. Many people wonder why this elimination of the fear has not yet occurred, since they have been exposed to the fear for months or even years. The answer is that people escape from their fears through compulsions and avoidance behaviors, thereby preventing sufficient exposure. But once the fears receive extended and repeated exposure to "the light of day," so to speak, they fade away and can even disappear.

Scientific studies show that these techniques significantly reduce symptoms in 75 percent of those treated (Foa and Kozak 1996). Furthermore, a study my UCLA colleagues and I conducted demonstrated that exposure and response prevention is associated with changes in the brain chemistry of OCD clients that are correlated with reductions in their symptoms (Baxter et al. 1992). For these and other reasons, most experts consider exposure and response prevention the treatment of choice for OCD. It will give you back your life. In addition, you will experience these benefits:

- Significant reductions or elimination of fear from situations that previously triggered it
- Few, if any, compulsions
- No avoidance of situations that were previously troubling
- Improved mood and self-confidence
- Higher self-esteem
- More time and energy for meaningful activities
- Better personal, social, vocational, and academic functioning
- The possibility of discontinuing medications

Here are excerpts of comments my patients have made after treatment: “Now I can do more since I stopped taking three or four showers per day,” from Sara who had no time for recreational activities. “Notice that I’m wearing a sleeveless blouse,” from Noreen who always wore pants and tops with long sleeves that covered her hands to prevent contamination. “See, my hands are looking a lot better,” from Tanya whose hands had been red, cracked, and bleeding. “I think I’ve had my last HIV test,” from Jerome who had multiple tests in efforts to quell his fear of AIDS. One of the most touching comments was from a military officer who had a twenty-two-year history of contamination fears: “If it weren’t for you, I wouldn’t be here. I had decided not to live with OCD.”

By fully participating in the treatment program given in this book, you will receive the same benefits as the individuals above and all the others who have learned how to use exposure and response prevention to recover from OCD.

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## IS THERE ANYONE ELSE LIKE ME?

You are by no means alone. The majority of my clients, at some point in the course of their disorder, have believed they were unique—the only ones afflicted with strange thoughts, anxious feelings, and senseless actions beyond their control. And as much as they'd ponder about the reasons for their condition, they usually drew the wrong conclusions. They would doubt the true nature of their being, and instead dwell on damning self-reprisals that they were inherently contaminated and spreading it, uniquely susceptible to disease, or abnormally irresponsible and careless about hygienic practices. For instance, no matter how much she washed and showered, applied lotions and scents, a meticulous senior accountant never felt really clean and worried about tainting others. Despite excessive washing and showering, a twenty-one-year-old college student could not ease the doubt that he was destined to contract a serious disease. A mother who diligently shielded her children from dangerous contamination she perceived as rampant in public places was convinced that she was not careful and responsible enough. For the people above, great relief followed when they learned they were suffering from a recognized medical condition with symptoms that signified nothing unique about them and that was shared by millions.

Until recently, reliable information on the number of people with OCD was totally lacking. In fact, it was thought that there were few. For instance, the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (1980), reported that “no information” was available on the percentage of people with the disorder. Some estimates did exist, however, which guessed that OCD affected as little as 0.05 percent of the population (Rudin 1953). It wasn't until 1988 that more reliable data, from a survey of 20,500 adults in five cities, determined that at some time during their lives, 2.5 percent of people in the general population will have OCD (Karno et al. 1988). This percentage is fifty times greater than the previous estimates and

means that, at any one time, over seven million people in the United States have or will have the disorder. This high frequency is two to three times higher than that of bipolar disorder (manic depressive illness), panic disorder, or schizophrenia.

Since approximately one of every forty people has OCD, it is quite possible that you have encountered a number of people with the condition. Exactly who, you do not know, due to the fact that most people with OCD keep it to themselves. Consider the probability that in a typical high school of two thousand students, approximately fifty students would have the problem. In a university of twenty thousand students, there would be four to five hundred. And in a city the size of Sacramento, California, there would be eight to nine thousand. So, you can see that you are by no means alone.

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## WHEN IT STARTS AND WHERE IT GOES

Studies show that OCD in adults usually starts in a person's early twenties (Antony, Downie, and Swinson 1998). In a study of thirty-one children and adolescents suffering from OCD, 29 percent of subjects reported that they developed symptoms at the age seven or less, 52 percent at the ages of eight to twelve, and 19 percent at ages thirteen and above (Hanna 1995). Several studies have shown that the occurrence of symptoms after the age of fifty is rare (Ingram 1961; Jenike 1991; Kolada, Bland, and Newman 1994).

Based on their experience, most mental-health practitioners have the impression that, without treatment, OCD tends to wax and wane over time. Rasmussen and Tsuang studied the course of the disorder in forty-four clients and found that 84 percent had no change in their condition, 14 percent worsened, and 2 percent had an up-and-down course. They also found that these patients, on the average, waited about seven and a half years to seek treatment after having their first symptoms (1986).

In the study, 25 percent could point to a specific stressful event just before the onset of their OCD, while 75 percent could not. Typical stresses included an increase in responsibility (like work or study overload) or a loss of some kind (like a death of a loved one or the loss of a job). Almost all the subjects believed that stress intensified

their symptoms. For some women, the stress of pregnancy can activate OCD symptoms. In one group of fifty-nine mothers with OCD, 39 percent reported that the disorder started during pregnancy (Neziroglu, Anemone, and Yaryura-Tobias 1992).

The significance of all these numbers is that OCD can strike a person early in life and, without treatment, will most likely persist. Although some can identify specific stressful events for its onset, most people cannot. Once OCD is present, however, almost all agree that life stresses worsen the symptoms. Probably the most important facts are that the disorder will not go away of its own accord, and that you can learn to significantly decrease or eliminate your symptoms and have a normal life.

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## WHY DOES IT HAPPEN?

We don't really know what causes OCD, but we do know what does not cause it. OCD is not due to flaws of character, such as moral or spiritual weakness or lack of courage. OCD is not a punishment for past actions or inactions for which you feel guilty. And there is no good evidence that faulty child-rearing methods, toilet training in particular, cause the condition. Furthermore, it is not a result of your irrational thinking. There are, however, mental health professionals who do believe that it is. Therefore to eliminate or reduce symptoms, these therapists attempt to teach the client to entertain rational thoughts to replace irrational ones. Not only does this technique fail, it can teach you new mental rituals that offer only a temporary relief and increase obsessions in the long run.

### Psychodynamic Explanations

One of the oldest theories suggests OCD is the result of psychological conflicts of which the individual is unaware. Therapists who hold this view believe that obsessions, because of their persistence, serve to block other more painful ideas from coming into a person's awareness. These painful ideas are usually unacceptable thoughts or urges of an aggressive or sexual nature that are in conflict with the person's values. Therapists of this school of thought believe that if

clients can develop insight into the existence and nature of the repressed conflict, it will be resolved and the obsessions will disappear. This type of treatment, variously called psychoanalysis, psychodynamic, traditional, or insight-oriented psychotherapy, has not been shown to be effective for OCD (Esman 2001). The most likely reason is that OCD is not caused by repressed psychological conflicts, but by problems with brain functioning.

### **The Chemical Superhighway—Serotonin**

OCD may be associated with insufficient levels of *serotonin*, a brain chemical necessary for the transmission of information across brain cells. Support for this possibility comes from the improvement seen in OCD patients after they've taken drugs that increase the availability of serotonin. It has also been observed that people with OCD have abnormally high metabolic rates in certain areas of their brains, which tend to decrease following treatment with either behavior therapy or medications (Baxter et al. 1992).

### **All in the Family—Genetics**

Genetic factors also appear to play a role. People with OCD have a significantly higher percentage of parents, siblings, and offspring with the disorder than people who do not have the disorder. Also, the frequency of OCD occurring in each identical twin is two times greater than OCD occurring in each unidentical twin (Billett, Richter, and Kennedy 1998).

### **Strep Infection—PANDAS**

In certain children, OCD symptoms emerge or are worsened during cases of strep throat. Research into the cause of this has led to speculation that the antibodies that fight the strep infection also attack nerve tissue in the basal ganglia of the brain. This results in OCD or tic symptoms. Susan Swedo, a behavioral pediatrician, has labeled this Pediatric Autoimmune Neuropsychiatric Disorder Associated with Strep (PANDAS). In cases where the onset of OCD or tic symptoms is sudden or dramatically worsened, strep infections should

be considered. Medical treatments with antibiotics may benefit some of these patients (Swedo, Leonard, and Kiessling 1994).

### **Behavioral Explanations**

For unknown reasons, the fear system in the brain sends false alarms of danger when it processes certain thoughts, images, or urges that most people simply ignore. For others, however, the thoughts persist and become triggers for intense fear bordering on terror, eventually becoming obsessions. Instinctively, the person tries to avoid these triggers, but this is impossible because triggers are everywhere. Thus, when contact is made, the victims somehow acquire the habit of using certain repetitive actions or mental activities that become compulsions used to get relief, albeit temporarily. From then on, they rely on compulsions and avoidance to cope with the fear. Adding even more anguish to the fear is the person's knowledge that it is unreasonable. "Why do I still react this way when I know it doesn't make sense?" they ask. They don't understand that reason alone is powerless in the face of irrational fear. Only direct confrontation through exposure to fear quiets the brain's fear system and stops the false alarms.

### **Biobehavioral Explanations**

Many people who study OCD view it as the result of a combination of biological and psychological responses to the inevitable stresses of life. People with OCD report that pressures from ordinary life events frequently preceded the onset of their symptoms. Even "positive" stresses such as graduating from school, moving, getting married, being promoted, having a baby, and so forth, have been associated with the appearance of symptoms. Psychological and physical trauma also seem to be a frequent precursor of the disorder. At UCLA, we observed that 30 percent of the chronic OCD client population had been victims of sexual, physical, or psychological trauma (Bystritsky et al. 1996). So it is plausible to consider that the cause of OCD may involve a combination of biological and environmental events. It seems that, when there is a biological predisposition for the disorder, the symptoms can manifest when sufficient environmental stress triggers them.

But enough of this theoretical talk, because even though we do not fully understand the causes of this disorder, we know enough about how it works to treat it. But first, let's discuss what's required for the diagnosis of OCD. Obviously the person must have obsessions and compulsions. Although each person's OCD has features that are unique to the person, there are several combinations of obsessions and compulsions that commonly occur. Let's take a look at them.

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## ABOUT OBSESSIONS AND COMPULSIONS

Obsessions are defined as recurrent and persistent thoughts, impulses, or images that are intrusive. They are inappropriate and persistent, and cause extreme anxiety or distress. Obsessions are not merely excessive worries about real life problems, but instead, they are anxieties about the occurrence of highly unlikely or totally unrealistic events. (A good example of this was Betty's realization that her obsessions of contracting AIDS from door handles was ridiculous.) The person realizes that the obsessions are caused by their own mind. Many people and mental-health professionals commonly refer to obsessions as worries or fears. In fact, the word "fear" is used synonymously with "obsession," because once the obsession starts, it instantaneously activates the fear response.

Compulsions are repetitive actions or mental activities that a person feels compelled to do following an obsession. The person thinks these activities will reduce distress or prevent something bad from happening. Frequently, they are excessive and not realistically connected to what they are designed to neutralize. Betty's washing activity illustrated this. As mentioned earlier, compulsions are frequently referred to as rituals.

### Frequently Occurring Obsessions and Their Compulsions

There are several types of obsessions that are quite common and trigger certain compulsions. Even though our focus in this book is on fears of being contaminated that lead to compulsive washing, it is good for you to be aware of other frequently associated obsessions and compulsions. Many of you may have more than one of them.

**Obsessions about being irresponsible or careless → Checking compulsions.** People with these obsessions are plagued by excessive and unreasonable doubts about safely and competently performing many routine activities of daily living, such as locking doors, turning off stoves, paying bills, and even driving. They will repeatedly check to be sure things were done correctly or that they have not unintentionally harmed someone. Yet for many, fear of blame or criticism for imagined negligence persists even though people with this form of OCD are far more careful and accident free than most of us.

**Harm obsessions → Repeating compulsions.** This type involves thoughts, impulses, or images of hurting others. A mother has images of killing her infant. A newlywed has thoughts of stabbing her sleeping husband. A young boy fears turning into a vampire and attacking his parents. These obsessions cause worries about being homicidal, going berserk, or even becoming a serial killer. Those of you with harm obsessions can take comfort in knowing that there are no known cases of people with OCD carrying out their harmful thoughts.

When people have harming thoughts or images, they may repeat whatever activity they were doing when the thought occurred, while trying to replace it with a good thought. They may repeatedly turn lights on and off, go back and forth through doorways, or tap themselves or objects. The repetitions are frequently carried out with counting.

**Sexual obsessions → Compulsive confessing and reassurance seeking.** These are unwanted persistent thoughts, images, or impulses of engaging in inappropriate sexual activities. A heterosexual man who regards homosexuality as unacceptable fears he is really gay. A son has images of sexual activity with his mother. A young woman will not allow people into her home because she fears she would lose control and have sex with them.

Confessing and seeking reassurance are common compulsions for coping with sexual obsessions. The person will tell a significant other of their unwanted sexual obsessions, and will seek reassurance that they won't carry out a perverse act or that they aren't a bad person. Mentally going over reasons why his or her fear won't materialize is common.

**Blasphemous obsessions → Praying and confessing compulsions.**

The obsessions are about thoughts, images, or impulses that are sacrilegious or against God and/or religion. Typically, such obsessions occur in those who are truly religious. Often their presence causes grave doubts and even worries of being possessed.

Mental compulsions of praying, making religious gestures, and repeating certain phrases in a ritualistic way are common attempts people make to deal with blasphemous obsessions. Confessing and reassurance seeking are also prevalent.

**Obsessions of losing or discarding something important → Hoarding.**

These obsessions cause people to fear that they might throw away something that is important, that they might need in the future, or that is in some way worthwhile. Consequently, they compulsively accumulate unneeded objects—old newspapers and magazines, receipts, unused clothing, aluminum cans, used food containers, and so on—to the point where the hoarded material occupies too much of their living space.

**Obsessions about symmetry and orderliness → Arranging and ordering compulsions.**

With this type, the person has intense anxiety when objects are not symmetrical or precisely arranged. He or she must hang shirts in the closet according to color, exactly equidistant from each other; objects on desks, tables, and other surfaces are placed in certain arrangements that must always be maintained; and footprints in the carpet are immediately smoothed out. Visitors to the person's home are not welcomed because they will inevitably disturb things and make work for the host who has to put everything back just as it was. The compulsions used to ameliorate the anxiety are to immediately put objects in their "correct" order.

**Unique obsessions → Unique compulsions.**

This category includes a host of obsessions that are highly unique to the individual. For example, a patient of mine feared that if she noticed things that caused her to think of blindness, that her daughter would go blind. To prevent this, she relied on a compulsion of immediately showering, even though she was fully aware of the lack of relevance of this behavior to preventing blindness. This is but one example of what are probably tens of thousands of unique obsessions.

People with OCD frequently look for examples of their particular form of the disorder in hopes of finding out that it was successfully treated. If they can't find an example of an obsession-compulsion combination like theirs, they feel discouraged. Don't be. Even frequently occurring obsessions and compulsions have unique features that vary from person to person. It is not what the obsessions and compulsions look like that is important, but how they work. Regardless of their form, obsessions are always about something that is highly unlikely or impossible yet provokes fear, and the compulsions are always some kind of excessive or inappropriate mental or physical action that temporarily reduces fear. Psychologists have discovered ways to treat OCD by disrupting this relationship, so the OCD disintegrates. I'll teach you how to do this in the chapters to come.

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## ACCORDING TO THE BOOK

Mental health professionals rely on the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, known as the DSM-IV (American Psychiatric Association 1994). This manual is used in diagnosing various mental conditions. The conditions necessary for the diagnosis of OCD are as follows.

**Condition A.** According to the DSM-IV, the person must have either obsessions or compulsions. However, all of the patients I've treated have had both obsessions and compulsions. This leads me to believe that they always work in combination.

**Condition B.** The person must recognize that their obsessions and compulsions are unrealistic and excessive. If most of the time the person does not recognize his or her obsessions or compulsions as excessive or unreasonable, then their diagnosis is given the additional specification of "with poor insight." This means they believe their fears are real, and their compulsions protect them from distress or something bad happening.

**Condition C.** The obsessions or compulsions must cause significant distress, consume a total time of more than one hour per day, or

significantly interfere with the person's occupational, educational, or social activities.

**Condition D.** The disorder is not considered OCD if there are obsessions or compulsions about food in a person with an eating disorder; hair pulling as a result of trichotillomania; excessive and inappropriate concern with appearance due to body dysmorphic disorder; preoccupation with drugs because of a substance use disorder; preoccupation with having a serious illness because of hypochondriasis; excessive sexual urges or fantasies due to paraphilia (intense sexual activity or desires involving unusual objects, activities, or situations); or guilty ruminations due to a major depressive disorder.

**Condition E.** The obsessions or compulsions are not a result of a substance, such as drugs of abuse, medications, or a general medical condition (like hyper- and hypothyroidism).

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## IT'S NOT ABOUT LOVE

It's worth discussing what OCD is not, since the words "obsession" and "compulsion" have meanings in everyday usage that are different from their use in OCD. When people say someone has an obsession about something, they usually mean that he or she has a fascination, preoccupation, fancy, or passion for it in the same way the person loves something or somebody. This is a positive state of affairs, and the person's behavior is under his or her own control. For example, when a young man finally meets the young woman of his dreams and finds that he cannot stop thinking about her, he is basking in the rapture of love, not trapped in the hellish prison of fearful, repetitive thoughts.

Obsessions should not be confused with symptoms of a major depressive episode or generalized anxiety disorder. In a major depressive disorder, the person is usually voluntarily engrossed in thoughts of self-worthlessness and guilt about past actions. In contrast, obsessions are involuntary and are concerned with dreaded future consequences. In generalized anxiety disorder, there is excessive worry about real-life circumstances, whereas obsessions are always focused on the unlikely or fantastic. Most people with OCD recognize the unreasonableness of their obsessions, except when they're in the

agony of them, at which time they may believe them. If, however, they are always convinced that their fear is real, then they are most likely suffering from delusional disorder.

The word “compulsion” also has a different meaning when used in an everyday sense as opposed to its OCD meaning. A woman may regularly clear her desk before leaving work and never fail to carefully wash her hands before preparing food. These actions are not necessarily compulsions if she finds satisfaction in them, and they do not interfere with the smooth flow of her life. Even the behaviors of excessive overeating, gambling, drinking, drug taking, smoking, sexual activity, and a variety of other bad habits are not considered compulsions, because people find them pleasurable and they are not triggered by obsessions.

Two additional conditions sometimes confused with compulsions are tic disorder and stereotypic movement disorder. In tic disorder, the person makes unexpected, rapid, repeated movements or vocalizations. Examples are eye blinking, tongue thrusting, and throat clearing. In stereotypic movement disorder, there are actions such as head banging, body rocking, and self-biting. Tics and stereotyped movements differ from compulsions because they are less complicated and not aimed at neutralizing obsessions. However, people can have symptoms of OCD, tic disorder, and stereotypic movement disorder at the same time.

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## AND IF THAT'S NOT ENOUGH

People with OCD frequently have other emotional and behavioral conditions, the most common being depression and other anxiety disorders (Antony, Downie, and Swinson 1998).

### Depression

Two studies found that approximately 30 percent of the OCD patients studied met the conditions of a major depressive episode (Karno et al. 1988; Yaryura-Tobias et al. 1996). This means they had five or more of the following symptoms nearly every day over a two-week period:

- Depressed mood most of the day
- Loss of interest or pleasure
- Significant weight loss or gain, or decrease or increase in appetite
- Insomnia
- Restlessness or slowness
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Difficulty thinking, concentrating, or making decisions
- Recurrent thoughts of death, suicidal thoughts with or without a specific plan, or a suicide attempt

The above symptoms must have caused significant distress or impairment in important areas of life and not be due to drug abuse, medication, or grieving the loss of a loved one.

Many people with OCD are clinically depressed, frequently as a result of the OCD, and once the OCD improves, the depression lifts. However, if the depression is severe, it can interfere with OCD treatment because one needs energy and concentration to complete the exercises that are part of behavior therapy. In such cases, it is probably best to address the depression first and then, after there is improvement, treat the OCD.

## **Anxiety Disorders**

It is not unusual for OCD sufferers to have other anxiety disorders, most commonly social phobia, specific phobia, panic disorder, and generalized anxiety disorder (Antony, Downie, and Swinson 1998).

- In social phobia, the person has an irrational fear of doing something embarrassing or being criticized when around other people.

- In specific phobia, there is a persistent, unreasonable fear, triggered by an object or situation (like flying, heights, animals, receiving an injection, seeing blood).
- In panic disorder, there are repeated attacks of unexpected, intense fear, accompanied by a number of bodily sensations of physical arousal, which causes people to fear they are having a heart attack, going crazy, or losing control.
- In generalized anxiety disorder, people worry excessively and are anxious about everyday life concerns of income, health, family, job, or education.

The presence of these anxiety disorders, which are also quite responsive to behavior therapy, does not necessarily preclude treating the OCD. The question is which should be treated first, or whether the anxiety disorders should be treated along with the OCD.

Reading about the above conditions might have caused some of you to worry that you have one of them and didn't realize it until now. If so, take comfort in knowing that these mood and anxiety disorders are quite responsive to treatment, just as OCD is. Also, you may be concerned that receiving a diagnosis of one of these disorders will cause you to be "labeled." I too find it objectionable when diagnoses are used as labels to classify people disapprovingly, for example, calling those with OCD "obsessives" or "compulsives." This has the effect of reducing a person to a mental disorder rather than regarding them as a human being with a disorder. However, there is considerable value in knowing and using the correct name for what ails you. These labels provide a framework for organizing our thinking so that problems can be systematically attacked and good treatment outcomes produced. Furthermore, some of these conditions exist, at some time to some degree, in most of us. You may be surprised to know that as much as 80 percent of the population experiences unpleasant, intrusive thoughts similar to obsessions (Rachman and De Silva 1978), and 55 percent performs compulsions (Muris, Merckelbach, and Clavan 1997). However, so-called "normal" obsessions and compulsions are less frequent, intense, and of shorter duration than those of OCD. It's when the level of distress interferes with your life flow that you should regard the condition as needing professional attention.

## Summary

With the information you have acquired from reading this chapter, you know at least as much about OCD as many mental-health professionals do, and more than some. Also, you should have a good idea about whether you have OCD. You have taken the first step toward your recovery. In the next chapter, we will examine the contamination-washing cycle, and by understanding how it works you will learn how to take it apart.