# CHAPTER 2

# A Closer Look at OCD: Symptoms and Causes

*Although the world is full of suffering, it is full also of the overcoming of it.*

—Helen Keller

In the United States, obsessive-compulsive disorder is the fourth most common psychiatric diagnosis, with a lifetime prevalence rate of up to 2.5 percent. This means one out of every forty people in this country—over 7.6 million men, women, and children—may suffer from OCD. As mentioned in chapter 1, previous estimates were much lower: 0.05 to 0.32 percent. Estimates today are as much as fifty times greater than in 1964 and 1967 (Yaryura-Tobias and Neziroglu 1997a). About 65 percent of people with OCD develop the disorder before the age of twenty-five, and only 15 percent develop it after the age of thirty-five. There is a slightly higher incidence of OCD in women. However, among children with OCD, boys outnumber girls by about two to one. Obsessive-compulsive disorder exists in every culture and on every continent (Niehous and Stein 1997).

What do these statistics mean to the average person with OCD? They provide confirmation that you are not alone. People with OCD tend to keep the illness a secret. As a result, you may not realize how many people have similar problems. Look around you next time you're amidst a large number of people—at a baseball game, concert, or mall, or even waiting in line at the department of motor vehicles. On average, it's likely that one out of forty people surrounding you has OCD.

The onset of OCD symptoms is usually gradual, although though some children suffer sudden onset in a form of OCD known as PANDAS (see chapter 17). It isn't uncommon for OCD symptoms to flare up during times of emotional stress at work or at home. Major life transitions such as leaving home for the first time, pregnancy, the birth of a child, the termination of a pregnancy, increased levels of responsibility, health problems, and bereavement may be linked to the onset or worsening of OCD symptoms.

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; American Psychiatric Association 2000) is the diagnostic bible for mental health professionals. In its criteria for a diagnosis of OCD, it states, "The essential features of obsessive-compulsive disorder are recurrent obsessions or compulsions... that are severe enough to be time-consuming (i.e., they take more than one hour a day) or cause marked distress or significant impairment... At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable" (American Psychiatric Association 2000, 456-457).

As explained in chapter 1, obsessions are persistent ideas, images, thoughts, or urges experienced as inappropriate and intrusive, and that cause marked anxiety. People with OCD have the sense that these thoughts aren't within their control and that they aren't the kind of thought that they would expect to have. They are also aware that the thoughts are a product of their own minds, versus externally imposed, which would be indicative of a psychotic disorder, not OCD.

In OCD, the discomfort of an obsessive thought or urge results in attempts to contain or neutralize the discomfort through some repetitive action, performed either covertly with thoughts, or overtly with behaviors. Repetitive overt behaviors include ordering, checking, or hand washing, while mental acts may include repeating words silently, praying, or counting. The function of a compulsive ritual or behavior is to reduce the distress that accompanies an obsessive worry or fear. It has the effect of containing, controlling, or neutralizing anxiety. People with OCD don't derive gratification or pleasure from performing their compulsions. They often feel driven to do them to prevent some dreaded situation—usually harm to others or themselves. Compulsions may be related to the content of the obsession but are clearly excessive, or they may not even be connected in a realistic way with what they are designed to neutralize or prevent.

## WHAT OCD IS NOT

In order to understand what OCD is, it's important to know what OCD is not. Almost everyone worries, at times excessively. The worries resulting from OCD differ in that they are usually senseless and irrational, and ignoring them makes the person feel anxious and nervous. It is important to distinguish this from worrying that is excessive but rational, which may be a symptom of depression.

Similarly, many people are compulsive without having OCD. They give careful attention to details and procedures and are overly concerned with rules, regulations, and doing things the "right" way. In contrast, the compulsions of people with OCD are senseless and repetitive and are performed to dispel anxiety. Most often, those with OCD consider their compulsions silly, pointless, and troublesome, and even embarrassing and shameful. People aren't always aware of these distinctions, so many forms of repetitive behavior may be mistakenly labeled as OCD, including superstition, ritual, and prayer; substance abuse and compulsive gambling; eating disorders; and obsessive-compulsive personality disorder.

## Superstition, Rituals, and Prayer

It is important to recognize that certain repetitive or ritualistic behaviors may be due to cultural or religious influences, not OCD. The *DSM* addresses this point:

> Culturally prescribed ritual behavior is not in itself indicative of obsessive-compulsive disorder unless it exceeds cultural norms, occurs at times and places judged inappropriate by others of the same culture, and interferes with social role functioning... Important life transitions and mourning may lead to an intensification of ritual behavior that may appear to be an obsession to a clinician who is not familiar with the cultural context...
>
> Superstitions and repetitive checking behaviors are commonly encountered in everyday life. A diagnosis of obsessive-compulsive disorder should be considered only if they are particularly time-consuming or result in clinically significant impairment or distress. (American Psychiatric Association 2000, 459)

Rituals and repetitive behaviors are part of the normal repertoire of behaviors we all possess. Prayer, for example, can be an important part of our daily lives. Most people perform some ritualistic and repetitive behavior in the normal course of daily life, and many people are superstitious. But when these behaviors take over, resulting in significant impairment, distress, or anxiety, or are excessively time-consuming, OCD could be responsible. In his workshops, OCD expert Robert Ackerman, MSW, aptly described OCD as a "cult of one."

## Substance Abuse and Compulsive Gambling

Although many problem behaviors are considered compulsive, they don't necessarily fit the clinical definition of OCD; and therefore aren't considered OCD. This is the case with pathological gambling and substance addictions, including addictions to drugs and alcohol. The main difference between OCD and these addictive or impulse control disorders is that the obsessive thoughts and compulsive behaviors of OCD are, for the most part, unwanted and unpleasant. Unlike addictions, OCD brings no anticipation of pleasure or satiation. Again, these behaviors are done to reduce discomfort and worry, not for pleasure.

## Obsessive-Compulsive Personality Disorder

When we hear the word "personality," we generally think of phrases describing people's overall behavior: "She has a nice, caring personality," "He has a strong, tenacious, domineering personality," and so on. Personality is a consistent, enduring, lifelong set of learned and inherited responses to a multitude of situations and challenges in life. It encompasses characteristics that don't change much throughout the life span.

When a personality style or a set of features fundamental to a personality causes an excess of stress or difficulty in life, the person is said to have a personality disorder. According to the *DSM* (American Psychiatric Association 2000), people with obsessive-compulsive personality disorder (OCPD) are

characterized by a preoccupation with details, rules, lists, orderliness, perfectionism, and mental and interpersonal control at the expense of flexibility, openness, and efficiency. They tend to view the world in black-and-white, all-or-nothing terms. There are no gray areas. They often adopt a "my way or the highway" approach to coworkers and family members, often referred to as "truth ownership," that damages and sours these relationships. For these people, it is unacceptable for their performance in any area of life to fall short of "perfection."

This pattern begins by early adulthood and is present in a variety of contexts in the person's life. In the area of work, people with this disorder tend to be highly efficient, reliable, and organized, but often excessively so. They may get overinvolved with the details of a task and lose the forest for the trees. In their personal lives, they spurn change and spontaneity, instead preferring predictability, repetition, and a highly routinized way of life. They tend to keep their emotions and behavior highly controlled and may appear rather cold and aloof to others.

Although people with OCD often have features of OCPD, only a small percentage of people with OCD (6 to 25 percent) actually have full-blown OCPD (Baer and Jenike 1998). The main difference between OCD and OCPD lies in the degree of life impairment. People with OCD suffer substantially from their problem and they wish to be rid of it. People with OCPD, on the other hand, are rarely uncomfortable about it and seldom feel the need for help for their problems. In fact, they are often unaware of the problem their behavior may be causing until these difficulties are brought to their attention by coworkers or family members who have been adversely affected by their behavior.

When a person with OCD also has OCPD, characteristics such as rigidity, perfectionism, and the need for control make it more difficult to change the OCD behaviors. This is mostly due to the reluctance of people with OCPD to accept guidance and intervention from outside themselves, as it implies that they are less than perfect. Unfortunately, when they do reach a point where they are ready to wholeheartedly face their problems, all may seem lost. However, hitting rock bottom often provides the opportunity and motivation to change. Elements of the self-directed program can be useful for people with OCPD. For example, they can use cognitive restructuring (covered in chapter 8) for perfectionism and "truth ownership," and exposure and response prevention to increase their behavioral flexibility in carrying out daily routines.

# THE SYMPTOMS OF OCD

Although OCD can manifest in a wide variety of ways, the most common symptoms are checking compulsions and washing or cleaning compulsions. Other symptoms include compulsive counting, the need for symmetry, unwanted sexual or aggressive thoughts, the need to constantly seek reassurance, ordering rituals, and hoarding. As discussed in chapter 1, some people have primarily obsessional OCD, meaning that they have obsessions but no overt compulsions. They are likely to have repetitive, unwanted, and intrusive thoughts of aggressive or sexual acts that are reprehensible to them. Others exhibit *primary obsessional slowness*, wherein their compulsive rituals and need to perform even the simplest daily tasks "just right" results in spending hours every day getting washed, dressed, and groomed.

The pattern of symptoms in OCD is extremely varied. While many people with OCD have one symptom throughout their lives, others have multiple obsessions and compulsions. For example, a checker may also be a washer. In addition, the symptoms may alternate and transform over the years.

For example, a person with intrusive thoughts in adolescence may get over that problem only to become a washer in early adulthood, and then become a checker later in life.

## Identifying Your OCD Symptoms

Below, you'll find a lengthy, detailed list of OCD symptoms related to obsessions, and another related to compulsions. Recognizing these symptoms can help the person with OCD come out of a self-imposed closet and seek treatment. Read through the lists and check off all of the symptoms that apply to you, or if you prefer, list your symptoms in your journal—just be sure to record them one way or the other. You'll use this list as you work your way through the self-directed program in this book. Recognizing that you have these symptoms is an important first step in understanding your OCD and developing a treatment plan. (And remember, having these symptoms is not sufficient to diagnose a person with OCD. OCD is diagnosed only when these behaviors result in significant impairment, distress, or anxiety, or are too time-consuming.)

## Identifying Your Obsessions

### CONTAMINATION OBSESSIONS

Excessive fear or disgust in regard to, and preoccupation with avoiding...

- ☐ Bodily waste or secretions, such as urine, feces, saliva, or blood
- ☐ Dirt or germs
- ☐ Sticky substances or residues
- ☐ Household cleansing agents or chemicals
- ☐ Environmental contaminants, such as radon, asbestos, radiation, or toxic waste
- ☐ Touching animals
- ☐ Insects
- ☐ Becoming ill from contamination
- ☐ Making others ill by contaminating them
- ☐ Diseases, such as AIDS, hepatitis, herpes, or other sexually transmitted diseases

### HOARDING, SAVING, AND COLLECTING OBSESSIONS

- ☐ Worry about throwing things away, even seemingly useless items

- ☐ Urge to collect useless things
- ☐ Feeling uncomfortable with empty space in the home and having a need to fill it
- ☐ Urge to purchase multiples of the same item
- ☐ Urge to maintain purchased items in pristine condition, resulting in not using them
- ☐ Urge to pick up useless items from the ground

## ORDERING OBSESSIONS

- ☐ Preoccupation with symmetry, exactness, or order
- ☐ Excessive concern that handwriting be perfect or "just right"
- ☐ Concern with aligning papers, books, and other items a certain "perfect" way

## RELIGIOUS OBSESSIONS AND SCRUPULOSITY

Excessive fear, worry, and preoccupation with...

- ☐ Having blasphemous thoughts and being punished for them
- ☐ Praying "perfectly"
- ☐ Violating, even slightly, religious rules or precepts
- ☐ The possibility of losing control and shouting expletives in a church or synagogue

## BODY IMAGE OBSESSIONS

Excessive fear, worry, and preoccupation with...

- ☐ Having a physical defect that makes you look ugly
- ☐ The possibility that others easily notice your perceived defect and consider it ugly

## HEALTH OBSESSIONS

Excessive fear, worry, and preoccupation with...

- ☐ The possibility of having a catastrophic illness despite being told you are healthy
- ☐ The possibility that you may be responsible for causing or not preventing a potentially catastrophic illness in yourself or a loved one

## AGGRESSIVE OBSESSIONS

Preoccupation with and excessive, irrational fear of...

- ☐ Losing control and harming yourself or others
- ☐ Acting on unwanted impulses, such as running over someone with your car
- ☐ Choking or stabbing someone
- ☐ Responsibility for some terrible accident, fire, or burglary due to personal carelessness
- ☐ Blurting out insults, obscenities, or racial epithets
- ☐ Doing something embarrassing or looking foolish

## SEXUAL OBSESSIONS

Unwanted, worrisome, and intrusive...

- ☐ Sexual thoughts, images, or impulses of "snapping" or losing control
- ☐ Thoughts of molesting your own children or other children
- ☐ Thoughts of groping others
- ☐ Thoughts of being or becoming a homosexual
- ☐ Preoccupation with the idea of committing violent, sexual acts toward others without knowing that you are doing it

## MISCELLANEOUS OBSESSIONS

- ☐ An unwanted urge to know, seek out, or remember useless information, such as slogans, license plate numbers, names, words, or historical events
- ☐ Fear of saying something wrong, not saying something just right, or leaving out details
- ☐ Worry about losing things
- ☐ Worry about making mistakes
- ☐ Worry that you didn't perfectly understand something you read
- ☐ Worry that you wrote imperfectly
- ☐ Worry that you wrote an expletive or racial epithet without knowing it

- ☐ Being easily bothered by certain sounds and noises, such as clocks ticking, loud noises, or buzzing
- ☐ Being easily bothered by the feel of clothing or other textures on the skin
- ☐ Intrusive nonsense sounds, music, or words
- ☐ Fear of saying certain words because of superstitious beliefs about those words
- ☐ Fear of using certain colors for superstitious reasons
- ☐ Excessive superstitious fears and rigid adherence to them
- ☐ Excessive concern with lucky and unlucky numbers

# Identifying Your Compulsions

## CLEANING AND WASHING COMPULSIONS

Excessive, illogical, and uncontrollable...

- ☐ Hand washing, often performed in a ritualistic way
- ☐ Showering or bathing, often performed in a ritualistic way
- ☐ Ritualistic tooth brushing, grooming, or shaving
- ☐ Cleaning of the house, certain rooms, the yard, sidewalks, or cars
- ☐ Cleaning of objects or household items
- ☐ Use of special cleansers or cleaning techniques
- ☐ Avoidance of objects considered contaminated
- ☐ Avoidance of specific places considered contaminated, such as cities, towns, or buildings
- ☐ Concern with wearing gloves or other protection to avoid "contamination"

## CHECKING COMPULSIONS

Checking over and over (despite repeated confirmation)...

- ☐ That you didn't harm others without knowing it
- ☐ That you didn't harm yourself
- ☐ That others didn't harm you

- ☐ That you didn't make a mistake
- ☐ That nothing terrible happened
- ☐ That you didn't do something that could cause future harm
- ☐ Some aspect of physical condition, such as appearance, or of health, such as pulse or blood pressure
- ☐ Physical surroundings, such as locks, windows, appliances, or stoves
- ☐ That jars are closed by excessive tightening
- ☐ That doors are closed by excessive, repeated shutting

## HOARDING, SAVING, AND COLLECTING COMPULSIONS

- ☐ Saving or collecting seemingly useless items
- ☐ Picking up useless items from the ground
- ☐ Difficulty throwing seemingly useless items away, as they might someday be useful

## REPEATING, COUNTING, AND ORDERING COMPULSIONS

- ☐ Reading and rereading things excessively
- ☐ Excessively writing and rewriting things
- ☐ Repeating routine activities, such as going in and out of doorways, getting up and down from a chair, combing hair, tying shoes, or dressing and undressing over and over
- ☐ Doing certain activities a particular number of times
- ☐ Counting items, such as books on a shelf, ceiling tiles, or cars going by
- ☐ Counting during compulsive activities, such as checking or washing
- ☐ Arranging items in a certain order, such as books, pencils, or objects in cupboards

## BODY IMAGE COMPULSIONS

- ☐ Excessively checking your body for signs of a physical defect
- ☐ Making extensive efforts to hide perceived defects from others
- ☐ Changing your appearance to hide or "fix" perceived physical defects

## HEALTH-RELATED COMPULSIONS

- ☐ Requiring repeated reassurance that you don't have a catastrophic illness
- ☐ Getting repeated medical tests
- ☐ Excessively checking your body (for example, your blood pressure or heart rate) for signs of disease
- ☐ Spending excessive time on the Internet researching symptoms of catastrophic disease

## MISCELLANEOUS COMPULSIONS

- ☐ Mental rituals, such as prayers or repeating "good" thoughts to counteract "bad" thoughts (with the intention of reducing or neutralizing anxiety)
- ☐ Reassuring self-talk or mantras stated over and over (with the intention of reducing or neutralizing anxiety)
- ☐ Excessive need to repetitively ask others for reassurance when ample assurance is evident to others and has already been provided
- ☐ Excessive need to confess "wrong" behavior, even the slightest insignificant infractions or perceived infractions against others
- ☐ Superstitious behavior that takes excessive amounts of time
- ☐ Need to touch, tap, or rub certain items or people
- ☐ Measures, other than checking, to prevent harm to self or others, such as avoidance of certain objects or extreme precautions to prevent highly unlikely harm or danger
- ☐ Eating ritualistically according to specific rules, such as arranging food or utensils, eating at certain times, or eating foods in a particular order

## OCD-RELATED COMPULSIONS

- ☐ Pulling hair from your scalp, eyebrows, eyelashes, or pubic area
- ☐ Acts of self-damage or self-mutilation, such as picking skin
- ☐ Compulsive shopping (often related to hoarding; for example, buying a number of things for fear of running out)

# HOW IS OCD DIAGNOSED?

The journey of recovery from OCD begins with an accurate diagnosis. If you suspect that you have OCD, you will find the following pages to be quite helpful in determining whether this is actually the case. If you aren't sure if you have OCD, it is possible that your uncertainty is actually a symptom of OCD. In any case, it's a good idea to obtain an accurate diagnosis from a qualified mental health professional if you haven't already done so.

A diagnosis of OCD is made on the basis of a psychiatric or psychological examination, a history of the person's symptoms and complaints, and the degree to which the symptoms interfere with daily functioning. Based on the nature, length, and frequency of the symptoms presented, the mental health professional will differentiate OCD from other conditions with similar symptoms. These include schizophrenia, phobias, panic disorder, and generalized anxiety disorder. A physical exam may be recommended to rule out other possible causes of the symptoms. There is no blood test available to reliably diagnose OCD. So how do mental health professionals distinguish between OCD and those people who just worry a great deal?

Studies have shown that 80 to 99 percent of people experience unwanted thoughts (Niehous and Stein 1997). But most people can hold unpleasant thoughts in their mind without too much discomfort, or they can easily dismiss the thoughts entirely. Their thoughts are shorter in duration, less intense, and less frequent than the intrusive thoughts of people who have OCD. The obsessive thoughts of OCD, on the other hand, usually have a specific onset, produce significant discomfort, and result in a powerful, overwhelming urge to neutralize or lessen them. The obsessions and compulsions of OCD significantly interfere with life. People with OCD recognize that they are excessive or unreasonable—at least most of the time.

There are several assessment tools that mental health professionals can use to aid in the diagnosis of OCD. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) is a questionnaire that can help target obsessive-compulsive symptoms and assess their severity. (We've included the Y-BOCS in the appendix to this book.) The Y-BOCS is also used to monitor the person's response to treatment. There is also a children's version of this scale. Other assessment tools include the Compulsive Activity Checklist (CAC), the Leyton Obsessional Inventory (LOI), the Maudsley Obsessive Compulsive Inventory (MOCI), the Padua Inventory (PI), and the National Institute of Mental Health Global Obsessive-Compulsive Scale (NIMH Global OC).

# OCD AND SHAME

People with OCD are typically secretive and shameful about their obsessive thoughts and compulsive behaviors. Many are successful in hiding their illness for years. Unlike people with many other mental illnesses, those with OCD are aware, at least at times, of their inappropriate behaviors and thoughts. However, they are often unaware that their symptoms are part of a recognizable condition that can be treated. Or they may fear that they'd be scorned, perhaps even locked up, if they were to reveal their obsessions and compulsions to others.

Because of this secretiveness, many people wait years, even decades, to seek help. Meanwhile, the obsessive thoughts and compulsive behaviors become more deeply ingrained in their lives. The average time between the onset of symptoms and seeking treatment is over seven years (Yaryura-Tobias and Neziroglu 1997b). Hopefully, further advances in scientific knowledge and understanding of OCD will narrow this time period.

Due to the shame people with OCD often feel, many won't consult a mental health professional. They may prefer to seek help for their symptoms from another type of health professional. Alert medical doctors can detect symptoms of OCD in people who come to see them for seemingly unrelated problems, and the family doctor may be the first professional to see signs of OCD in a person. Parents and family members may mention their concern about the person's frequent washing, counting, or checking. Excessive worry about having AIDS or other serious illnesses, resulting in repeated unnecessary tests and consultations, may also alert physicians.

Other doctors likely to detect signs of OCD include dermatologists, plastic surgeons, dentists, obstetricians, neurologists, neurosurgeons, orthopedic surgeons, pediatricians, infectious disease internists, and even oncologists. Dermatologists may notice chapped hands and eczema-type conditions due to excessive hand washing. People with perfectly normal appearances may present themselves to plastic surgeons requesting surgery for what they feel are noticeable deformities. A dentist may be alerted by gum lesions from excessive teeth cleaning. An orthopedic surgeon may be consulted for musculoskeletal or joint problems arising from repetitive motion activities, such as repeatedly pressing the refrigerator door to make sure it's shut. Signs of OCD may intensify during pregnancy and postpartum and therefore be noticed by obstetricians. Neurologists and neurosurgeons see signs of OCD associated with Tourette syndrome, head injury, epilepsy, and other disorders of the nervous system (discussed later in this chapter). The informed physician with a keen eye will detect OCD and make the appropriate referral to a psychiatrist or other mental health professional, rather than dismissing the person as odd or crazy.

## OCD AND DEPRESSION

Many people with OCD suffer from some degree of depressive symptoms, ranging from mild ("the blues") to severe, life-threatening depressive illness characterized by strong, persistent feelings of sadness, hopelessness, helplessness, loss of interest in normal activities and pursuits, lack of energy, impaired sleep and appetite, and suicidal thoughts. At the time they seek treatment, approximately one-third have major clinical depression—the most severely disabling form of depression—and about two-thirds of people with OCD have had at least one episode of major clinical depression in their lifetime (Jenike 1996). Many others suffer from a lesser form of depression known as *dysthymia*—a kind of low-grade depressed mood. Most people with OCD who also have dysthymia are depressed because OCD imposes severe limits on quality of life. For these people, successful treatment of OCD often results in a lifting of the dysthymia.

There is some controversy about whether depression is a separate disease, independent from OCD, or a secondary disease caused by the OCD. In one study, 56.9 percent of people with OCD were diagnosed with a major depressive episode first. Some OCD experts estimate that 90 percent of people with OCD have depression secondary to their OCD (Yaryura-Tobias and Neziroglu 1997b).

Interestingly, many of the medications used to treat depression also work well for OCD, which may indicate that similar issues in regard to brain structure and neurochemical abnormalities are at work in the two disorders. Undoubtedly, further research will reveal more about the connection between OCD and depression. Perhaps depression is a natural outgrowth of having a devastating disease such as OCD. Indeed, it can be depressing to suffer from OCD.

If OCD is an issue for you, it's important to be on the lookout for the warning signs of major clinical depression, since those with major depression often lack the perspective to see what's happening to them. For the same reason, it's also important for doctors and family members to watch for warning signs of major clinical depression. The presence of major clinical depression complicates the treatment of OCD. If you are severely depressed, you may not benefit fully from the self-directed program presented in this book due to the learning and memory deficits typical of major clinical depression. The diagnosis of depression is best made by a licensed mental health professional, who may use a variety of clinical tools to assess the likelihood and severity of depression.

To help you determine whether you may be depressed and therefore should consult with a mental health professional about this, we've provided a couple of assessments. The first is a list of the signs of major clinical depression. Check off all that apply to you (or write them on a separate sheet of paper):

- ☐ Depressed mood most of the day, nearly every day
- ☐ Markedly diminished interest or pleasure in all, or almost all, activities
- ☐ Significant weight loss or gain, or decrease or increase in appetite nearly every day
- ☐ Insomnia or excessive sleep nearly every day
- ☐ Feelings of extreme restlessness or being slowed down
- ☐ Fatigue or loss of energy nearly every day
- ☐ Feelings of worthlessness or excessive or inappropriate guilt nearly every day
- ☐ Diminished ability to think or concentrate, or indecisiveness, nearly every day
- ☐ Recurrent thoughts of death or of suicide (without a specific plan), or a plan for committing suicide or an actual attempt

The diagnosis of major clinical depression requires that you have at least five of the symptoms above, that they are present for two weeks, and that there is a marked change in your previous functioning. In addition, one of the symptoms must be either depressed mood or diminished interest or pleasure in activities (American Psychiatric Association 2000).

A second way of assessing whether you may be depressed is a self-rating measuring instrument like the Zung Self-Rating Depression Scale (Zung 1965), which follows. For every statement in the left column, check the response that describes how you *presently* feel.

| *Zung Self-Rating Depression Scale* | | | | |
|---|---|---|---|---|
| | Never | Sometimes | Most of the time | All the time |
| I feel downhearted and blue. | | | | |
| Morning is when I feel the best. | | | | |
| I have crying spells or feel like it. | | | | |
| I have trouble sleeping at night. | | | | |
| I eat as much as I used to. | | | | |
| I still enjoy sex. | | | | |
| I notice that I am losing weight. | | | | |
| I have trouble with constipation. | | | | |
| My heart beats faster than usual. | | | | |
| I get tired for no reason. | | | | |
| My mind is as clear as it used to be. | | | | |
| I find it easy to do the things I used to do. | | | | |
| I am restless and can't keep still. | | | | |
| I feel hopeful about the future. | | | | |
| I am more irritable than usual. | | | | |
| I find it easy to make decisions. | | | | |
| I feel that I am useful and needed. | | | | |
| My life is pretty full. | | | | |
| I feel that others would be better off if I were dead. | | | | |
| I still enjoy the things I used to do. | | | | |



**Scoring**

For questions 1, 3, 4, 7, 8, 9, 10, 13, 15, and 19, give yourself 1 for never; 2 for sometimes, 3 for most of the time; and 4 for all the time. For questions 2, 5, 6, 11, 12, 14, 16, 17, 18, and 20, give yourself 4 for never; 3 for sometimes; 2 for most of the time; and 1 for all the time. Then total your score. Calculate

your rating as follows: Divide your score by 80, then multiply by 100. This number is your depression rating. Here's a key to what the ratings mean:

| | | |
|---|---|---|
| Below 50 | = | Within the normal range |
| 50 to 59 | = | Minimal to mild depression |
| 60 to 79 | = | Moderate to marked depression |
| 70 or more | = | Severe to extreme depression |

Use this scale to determine where you might stand. If you find that you're moderately to severely depressed, tell your doctor about your score on this test immediately and discuss it together. Effective treatment for depression is widely available. Improving depression can pave the way for you to break free from OCD.

If you have major clinical depression, especially with accompanying suicidal thoughts, even if those thoughts occur only occasionally, we urge you to seek help from a qualified mental health professional now. Most cities and states have a suicide hotline that can help you find and obtain the help you need. Whether the person who is thinking of or talking about suicide is you, a family member, or a friend, don't hesitate. *Get help immediately.*

# WHAT CAUSES OCD?

No one knows exactly what causes OCD, but researchers are piecing together the puzzle. It appears that OCD results from a combination of genetically inherited tendencies or predispositions, together with significant environmental factors. Inherited tendencies include subtle variations in brain structure, neurochemistry, and circuitry. Environmental factors include psychological and physical trauma, childhood neglect, abuse, family stress, illness, death, and divorce, plus major life transitions, such as adolescence, moving out to live on one's own, marriage, parenthood, and retirement. Inherited biological predispositions serve as a kind of tinderbox, which, when combined with environmental lightning bolts, can ignite and activate OCD symptoms.

## Does OCD Run in Families?

OCD appears to be, at least in part, a genetically inherited disorder. One indication is that OCD is more prevalent among identical than fraternal twins (Billett, Richter, and Kennedy 1998). Studies going back as far as 1930 have found OCD traits in blood relatives at rates of 20 to 40 percent (Yaryura-Tobias and Neziroglu 1997b). In addition, there may be higher rates of subclinical OCD, tics, and Tourette syndrome among relatives of people with OCD (Alsobrook and Pauls 1998), and those with childhood-onset OCD are more likely to have a blood relative with OCD (Geller 1998).

Yet while OCD often appears to run in families, the exact mechanism by which it is transmitted from generation to generation isn't well understood. Genetics probably plays a role, but as of yet, researchers believe there is no specific gene that causes OCD. Rather, it is suspected that several genes

may work in concert to contribute to a vulnerability to OCD. Genetics seems to play more of a role in childhood-onset OCD than in OCD that occurs initially in adulthood (Abramowitz, Taylor, and McKay 2009). More research is needed, and more is presently being done.

## Neurological Factors

The most widely held biological theory of OCD is that it is related to abnormal functioning of one of the brain's vital chemical messengers: serotonin. Serotonin plays a role in many biological processes, including sleep, appetite, body temperature, pain, mood, aggression, and impulse control. Serotonin dysregulation has also been implicated in other mental illnesses, including depression, eating disorders, self-mutilation, and schizophrenia (Yaryura-Tobias and Neziroglu 1997b).

Serotonin is in the class of chemicals known as *neurotransmitters*, compounds that nerve cells use to communicate with one another. Neurotransmitters do their work in the small space between two nerve cells, called the *synaptic cleft*. The transmission ends when the neurotransmitters are absorbed back up into the transmitting cell, a process known as *reuptake*. Certain medications can increase the amount of serotonin available, apparently by causing changes in the receptors in some of the membranes of the nerves. It is believed that these receptors may be abnormal in people with OCD (Jenike 1996).

More recent studies indicate that the brain chemical glutamate may play a role in OCD (Lafleur et al. 2005; Coric et al. 2005). Like serotonin, glutamate is a brain neurotransmitter that is vital to optimal brain function. Recently, drugs that improve the regulation of glutamate in the brain, such as riluzole (Rilutek) have been found to improve OCD symptoms in people who don't respond to other treatments.

In addition to dysregulation of neurotransmitters, structural problems in the brain may play a role. Brain-imaging studies have demonstrated abnormalities in several parts of the brain in people with OCD. These include the thalamus, caudate nucleus, orbital cortex, and cingulate gyrus.

The *thalamus* processes sensory messages coming to the brain from the rest of the body. The *caudate nucleus* is part of the *basal ganglia*, located deep in the center of the brain. The caudate nucleus controls the filtering of thoughts. Sensory information is sorted here. Normally, unnecessary information is disregarded. In people with OCD, the caudate nucleus isn't as effective at filtering, so they become overwhelmed with intrusive thoughts and urges. The caudate nucleus of a person with OCD is like a doorman who does a poor job keeping out the undesirables.

The *orbital cortex* is in the front part of the brain, above the eyes. This is where thoughts and emotions combine. The orbital cortex tells us when something is wrong and when we should avoid something. It's like an early warning system in the brain, and it seems to work overtime in people with OCD. When the caudate nucleus lets unnecessary thoughts and impulses through, this makes the orbital cortex's job much more difficult.

The *cingulate gyrus*, located in the center of the brain, helps shift attention from one thought or behavior to another. When it's overactive, we get stuck in certain behaviors, thoughts, or ideas. The cingulate gyrus is also the part of the brain that signals danger, and as such, it's the part that says something horrible will happen if you don't carry out your compulsions.

Imagine all of these parts of your brain screaming at you when your OCD symptoms are at their worst:

- The thalamus sends messages from other parts of the body, making you hyperaware of everything going on around you.
- The caudate nucleus opens the gate and lets in unwanted intrusive thoughts.
- The orbital cortex mixes thoughts with emotions, then tells you, "Something is wrong here! Take cover!"
- The cingulate gyrus tells you to perform compulsions to relieve the anxiety the rest of your brain has heaped on you.

By now you're probably thinking, "No wonder I have problems!" Hopefully, you're also starting to realize that your OCD isn't your fault. It's your brain! Of course we have simplified this greatly, and experts still aren't even sure exactly what different parts of the brain do. As we said, the puzzle is still being pieced together.

## Other Physiological Factors

Research has found that certain autoimmune diseases, such as rheumatic fever, pediatric streptococcal infections, lupus, and Sydenham's chorea, also may be related to some instances of OCD (Mell, Davis, and Owens 2005; Pavone et al. 2006; Huey et al. 2008). In addition, some studies have shown an association between OCD and head trauma, brain tumors, epilepsy, hypothalamic lesions, and von Economo's encephalitis (encephalitis lethargica). However, most cases of OCD don't have such dramatic causes (Jenike 1998; Yaryura-Tobias and Neziroglu 1997b). In chapter 17, we'll further discuss pediatric autoimmune neuropsychiatric disorder associated with streptococci (PANDAS), a rare autoimmune reaction that sometimes causes OCD symptoms in children.

# THERE IS HOPE!

Although many processes remain unclear, there is increasing evidence that problems with the neurochemistry, circuitry, and structure of the brain play a significant role in OCD. In addition, environmental or developmental events are likely to affect the onset, expression, and severity of the symptoms. One thing that is clear is that parents, spouses, and other family members are not to blame for OCD. Regardless of the role any specific factors—genetic, biological, or environmental—play in the appearance of OCD in any one individual, there is hope. Medication can help correct serotonin dysregulation. And studies have found that cognitive behavioral therapy can bring about positive changes in brain function (Nakatani et al. 2003). Together, these powerful treatment strategies can help you break free from the grip of OCD.

# HELP FOR FAMILY AND FRIENDS

This chapter defines OCD: what it is, the symptoms, how it's diagnosed, and potential causes. Read this chapter carefully. It will give you a better understanding of your loved one's illness. As we noted, people with OCD often feel ashamed and are secretive about their obsessive thoughts and compulsive behaviors. Your loved one may be hiding symptoms from you. As both of you gain a better understanding of OCD, your loved one will be more open, especially if you show that you're willing to learn and try to understand. Notice that we say *try* to understand. No one can fully understand what someone else is going through.

Learning what you and your loved one are dealing with is a beginning. Both of you will probably experience a host of feelings as you embark on this journey toward recovery: relief at finding hope, fear of the unknown, acceptance, a release of shame and embarrassment, uneasiness about trying cognitive behavioral therapy, and more. Discuss these feelings, both positive and negative, with your loved one.