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Uncovering OCD

Does it have a connection to sensory-integrative disorders?

By Jessica LaGrossa

Statistics say that one in 50 adults in the United States currently may have obsessive-compulsive disorder (OCD), an anxiety disorder of repetitive thoughts and behaviors that are senseless and distressing, but extremely difficult to overcome. According to the Obsessive-Compulsive Foundation, a private advocacy organization, twice that many people actually have been diagnosed with OCD at some point in their lives. (www.ocfoundation.org)

Surprised by the statistics? You aren't the only one.

"I think a lot of people don't realize how common [OCD] is," David Baron, MSEd, DDO, professor and chair of the department of psychiatry at Temple University School of Medicine, in Philadelphia, PA, told *ADVANCE*.

In the past, mental health professionals thought OCD to be a rare disease because they treated such a small minority of patients with the disorder. However, professionals soon learned that the diagnosis wasn't rare at all; instead, it was the number of people willing to seek help for their abnormal obsessions and compulsions who were few and far between.

"A lot of people think they are going crazy when they [become obsessive-compulsive] because they know they are having strange thoughts that don't make sense, but they can't help themselves," said Dr. Baron. "[Having] OCD does not mean you are going to end up psychotic, but because people are fearful of that, they deny [the

obsessions and compulsions] and suffer in silence."

With so few people seeking treatment, gross inaccuracies in the estimated number of people with the illness went on for years. Then, in the early 1980s, the National Institutes of Mental Health (NIMH) conducted a survey that provided new knowledge about the prevalence of OCD. Results revealed that OCD affects more than 2 percent of the population, making the disorder more common than such severe mental illnesses as schizophrenia, bipolar disorder or panic disorder. (www.nimh.nih.gov/publicat/ocd.cfm#ocd1)

You also might be surprised to find that some psychologists see a possible relationship between OCD and sensory-integrative disorders.

What is OCD?

OCD is comprised of two elements: obsessive thoughtsunwanted, obtrusive and causing distressand compulsions, the behaviors that are used to neutralize the anxiety the obsessions cause.

"At the moment you are doing a particular compulsive behavior, the anxiety associated with the obsessive thoughts goes down," explained Dr. Baron. "But as soon as you stop [the behavior], the anxiety comes back. The compulsive behavior is a feeble attempt at relieving the anxiety, which is the driving mood state associated with the obsessional thoughts."

In almost all cases, obsessions and compulsions are both present for diagnosiseven when compulsive behaviors aren't apparently present. This situation is known as obsessional OCD, which, according to Tom Corboy, MFT, founder and director of the OCD Center of Los Angeles, looks to the outside world to be OCD without compulsions.

"But I have never seen a case where a person with obsessional OCD didn't have some compulsions that are less obvious," said Corboy. "Those compulsions are quite often avoidant behaviors, made in an attempt to make certain there is no onset of the obsession."

Corboy currently has a client who suffers from "hit and run OCD" who refuses to drive. "He is afraid he will start having the obsessive thoughts again (that he will run people over) if he gets behind the wheel of a car."

Clients such as this may believe that they don't have any compulsive behaviors, but their compulsions are the avoidant behaviors.

OCD Spectrum

But if OCD is much better understood today than it was 10 years ago, it is still baffling and frustrating in many ways. A number of conditions that have obsessive and compulsive features fall into the OCD spectrum, a loose category of disorders, but which conditions apply to it can depend on whom you are talking to, explained Corboy. "Some people include a broad range of disorders, and some are less likely to include such a broad range."

For example, he said, some people would say that compulsive gambling and compulsive shoplifting are part of the obsessive-compulsive spectrum; he personally doesn't agree.

Meanwhile, according to Dr. Baron, a variety of OC behaviors interfere with day-to-day life, and they can fit the spectrum. "If you talk about OCD as being driven to do a behavior that you would otherwise not want to dorealizing that it isn't right or doesn't make sensel think that it fits into the spectrum."

"There are a handful of conditions that virtually everybody agrees are part of the spectrum," said Corboy. "Most notable are body dysmorphic disorder, hypochondriasis, trichotillomania (compulsive hair pulling), and neurotic excoriation (compulsive skin picking)."

Dr. Baron believes that as progress in the area of genetics continues, biochemical reasons will more than likely be identified as to why these disorders are similar.

Causes of OCD

Once thought to strictly be a psychological disorder, research has revealed that the causes of OCD can be found in the brain. "There are certainly psychological issues that play into it," Dr. Baron told ADVANCE. "But those with OCD have altercations in the way that their brains function."

According to the National Institute of Mental Health, the fact that patients with OCD respond well to specific medications that affect the neurotransmitter serotonin suggests the disorder has a neurobiological basis.

In addition, symptoms of OCD can also be seen in association with other neurological disorders, such as Tourette's syndrome. Current research is looking into the genetic relationship between OCD and tic disorders.

Other theories suggest that the interaction among behavior, the environment and beliefs and attitudes contribute to the cause of OCD, as well as cognitive issues that are not incompatible with biological explanations. (www.nimh.nih.gov/publicat/ocd.cfm#ocd1)

Corboy agreed, saying that while there is "a fair amount of research at this point indicating that OCD has a neurological base and is, to some extent, an inheritable condition...there is a learning component to OCD, too.

"Through the repeated act of compulsions, a person basically learns to respond to obsessions in a specific fashion in an effort to neutralize the anxiety caused by obsessions," he explained.

According to research, roughly 50 percent of people diagnosed with OCD get it as children, in which case it appears to be primarily an inherited trait. However, when the onset of symptoms occurs in adulthood, OCD seems to be more of a learned trait.

"Although I suspect that, over time, research will discover that there is a neurological inheritable basis to adult onset OCD as well," added Corboy.

PANDAS

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Most recently, researchers have begun to consider biological causes of OCD. While addressing nearly 500 psychiatrists in May of 1998 at a New York University Medical Center postgraduate course, Susan Swedo, MD, head of the behavioral pediatrics section in the child psychiatry branch of the National Institute of Mental Health (NIMH), acknowledged a distinct subgroup of patients in whom symptom exacerbation is triggered by streptococcal (Strep) infections.

According to Dr. Swedo, several clinical observations occurring parallel led to the identification of this subgroup known as pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS).

A series of studies at the NIMH in 1994 demonstrated that children with Sydenham's chorea (acute manifestation of rheumatic fever) had acute-onset obsessive-compulsive symptoms in about three-quarters of the cases.

Follow-up studies the next year revealed a subgroup with abrupt onset symptoms, spontaneous remissions, or an episodic course that parents would describe as happening overnight.

Dr. Swedo gave the dramatic example of a 12-year-old girl who, after going to bed healthy, was unable to make it down the stairs in the morning due to a sudden onset of repetition rituals.

Clinical observations have led to five criteria for the diagnosis of PANDAS:

1) Patients must have OCD or a tic disorder;

2) Pediatric onset of symptoms;

3) A clinical course characterized by abrupt onset or dramatic exacerbation of symptoms;

4) Symptom exacerbation is temporally related to group A beta-hemolyticstreptococcal (GABHS) infections;

5) Neurologic abnormalities during symptom exacerbation.

Dr. Swedo told the group that her team now tests for Strep throat infections in children with tics, OCD or choreiform movements with an abrupt onset or exacerbation, or a loss of a medication response.

According to Corboy, such suggestions of PANDAS have been quite controversial. "The problem is that all of this research is preliminary," he told *ADVANCE*. "It has only been [undertaken] in the last few years. Some people are saying that it's not legit, while some are saying it is; but there does seem to be something there."

Diagnosing OCD

"The diagnosis is a fairly simple one," Dr. Baron said of OCD. "There are a number of scales such as the Y Box, and the Yale Brown Obsessive Compulsive Scale, but clinically, you ask [two questions]: 'Do you have a thought or thoughts that go over and over in your mind that you try to get rid of but you can't?' and 'Do you have a behavior that you have to do that may not make any sense, but that you have to do it in order to relieve the anxiety?'"

He explained that in diagnosing OCD, you are looking to determine whether or not the obsession(s) interfere with day-to-day life. "By the diagnostic criteria psychiatrists use, it has to take up a portion of the day and interfere with their functioning," he added. "And often the thoughts and acts are senseless, and the people know they are senseless."

Dr. Baron explained that the word "obsess" tends to be overly used in our society. Determining whether or not one's "obsession" can be classified as OCD is a matter of how much time the person spends on the topic.

One must also consider whether or not the "obsession" is a positive or negative influence in their life. "Someone may say they think all day of praying because they are a devout person," explained Dr. Baron. "Is that OCD? No, that isn't something they are trying to get rid of. To be OCD, the thought has to be an obsessional thought that you try to get rid of and can't.

Treatment

Today, the most accepted form of treatment for OCD is cognitive behavior therapy (CBT). And according to Corboy, a very specific type of CBT is most effective. "Significant outcome studies have been done over the past 10 years, and research has shown that, by far, the most effective treatment for OCD is exposure and response prevention (ERP)."

Rather than discussing the obsessive-compulsive issues with a therapist as in traditional psychotherapy, the goal in ERP is to systematically identify the person's obsessions and compulsions and to address them with a structured treatment protocol in a structured manner to get rid of the symptoms, said Corboy.

ERP consists of two stages: the exposure and the response prevention. "The exposure stage is to expose clients to the very thing that scares them," explained Corboy. He gave an example of a client obsessing over germsin particular, AIDSon doorknobs.

"The idea would be to have him put his hand on the doorknob and to keep it there," explained Corboy. "This is going to cause a tremendous amount of anxiety at first, because the person has basically learned to have an overanxious response to the possibility of getting AIDS from a doorknob, which is, as you and I know, virtually impossible."

In the response stage, the therapist encourages the client not to give in to the urge to act out his compulsive response. In the above example, Corboy explained, the typical response of the client could be to take his hand away from the doorknob, to go rushing into the bathroom to wash his hands, to take off his clothes because they are apparently contaminated, and/or go straight to the shower.

"The client will basically, over time, desensitize to the feared threat," Corboy said. "If he leaves his hand on that doorknob long enough, that anxiety spike that really scares him when he first touches the doorknob will dissipate in time."

A typical session at Corboy's OCD center usually lasts 45 to 50 minutes. In the beginning stages of therapy, the

therapist and client will cooperatively create what is called a hierarchya rank-ordered list of the client's obsessive and compulsive symptoms.

"At the top of the hierarchy is the thing that causes the least anxiety and will be the easiest thing for the client to challenge and at the bottom of the list is the thing that causes the most anxiety and will be the hardest for him to challenge," explained Corboy. "Then we will start addressing them one by one, with the goal being to get the client to desensitize his anxiety response to the alleged threats."

Corboy pointed out that while ERP is not a cure for OCD, it is the most effective management therapists have for the disorder.

Medication also can be an option in severe cases. Dr. Baron told *ADVANCE* that serotonergic agents such as Prozac have been shown to be very effective. "But you have to go to fairly high doses, much greater than what you would use for depression," he explained.

Overlapping Illnesses

Symptoms of OCD can be seen in association with other neurological disorders such as Tourette's syndrome, where complex tics, touching or tapping may closely resemble compulsions. Tics and OCD occur together most often when the OCD or tics begin during childhood. (www.ocfoundation.org)

And, according to Dr. Baron, about half of OCD patients also will end up with depression, which seems to be more common for adults than adolescents.

Children and adults with pervasive developmental disorders (PPDs) such as autism display the stereotypical behaviors of rigidity and compulsiveness that can also closely resemble very severe OCD. However, those with PPDs have severe problems relating to and communicating with other people, which do not occur in OCD. (www.ocfoundation.org)

Corboy told *ADVANCE* that the center has seen a number of children, and a couple of adults, with sensory integration difficulties in the past year. "When you look at [OCD and SI disorder] next to each other, they look very similar," he said. "And the treatment for the two of them is very similar."

Realizing that OTs don't refer to the therapy they do with SI clients as ERP, Corboy believes that the two approaches are basically the same, and are equally effective.

"We are finding that using ERP with particular [SI] symptoms is virtually identical to doing it with the more standard OCD symptoms," he explained. "The difference being that [SI] is very physiologically based (it is similar to OCD in that respect), but it is more rooted in the client's sensorium as opposed to the cognitive processes. But I don't think you can separate the sensorium process from your cognitive processes."

Because Corboy sees the sensorium and cognitive processes as related, he believes there is a "good chance that there is a tremendous amount of overlap" between SI disorders and OCD.

Dr. Baron hasn't seen any scientific data to support that OCD and SI are related, but he wouldn't discount the hypothesis. "You are talking about something where there are alterations in the brain as to the way the brain is functioning," he said. "What you see [in OCD] is some of the symptoms that you see with autism, including the repetitive behaviors; the symptoms might overlap."

Most clients following a structured CBT protocol at Corboy's OCD Center begin to see significant improvement by meeting with their therapist on a weekly basis over a period of four to six months. Many clients also join the center's ongoing weekly OCD support group.

"Many people who have OCD are quite bright and fairly well accomplished," explained Dr. Baron. "These people don't have to suffer in silence; [OCD] is very treatable condition" with "effective treatments."

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