International Journal of Science and Research (IJSR)
ISSN: 2319-7064
Impact Factor 2024: 7.101

The Interpersonal Relationships of Obsessive Compulsive Disorder

Kulandai Therese

T. John College of Nursing, Bannerghatta Road, Chikkamanahalli, Bangalore 560083, Karnataka, India
Email: *theresafsmp7[at]gmail.com*

Abstract: ***Obsessive-Compulsive Disorder (OCD) is a chronic mental health condition marked by recurring obsessions and compulsions that cause distress and impairment. Obsessions are intrusive thoughts, urges, or images that provoke anxiety, while compulsions are repetitive behaviours aimed at reducing distress. The disorder stems from complex biological, genetic, neurophysiological, and environmental interactions, with neurotransmitter dysregulation, particularly serotonin, playing a key role. Common themes include contamination fears, intrusive thoughts, and compulsive behaviours such as excessive handwashing and checking. Comorbid conditions like anxiety and depression often complicate diagnosis and treatment. Management involves cognitive-behavioural therapy (CBT), especially exposure and response prevention (ERP), along with selective serotonin reuptake inhibitors (SSRIs). For treatment-resistant cases, deep brain stimulation (DBS) and transcranial magnetic stimulation (TMS) are emerging options. Beyond clinical treatment, lifestyle modifications, stress management, and support groups help improve symptom control and quality of life. Research continues to advance treatment strategies for OCD.***

Keywords: Obsession, compulsion, compulsive behaviours, intrusive thoughts, OCD symptoms, cognitive therapy, serotonin imbalance

1. Introduction

Obsessive -Compulsive Disorder is a mental disorder whose main symptoms include obsessions and compulsions, driving the person to engage in unwanted, often -times distress behaviours or thoughts. The obsessions are usually related to a sense of harm, risk or injury. The common Obsessions include concern about contamination, doubt, fear of loss or letting go, feat of physically injuring someone. Its treatment is done through a combination of psychiatric educations and psychotherapy.

2. Definitions

Obsessions: Obsession is a recurrent and persistent thought, impulse, or image that causes distressing emotions such as fear or disgust. These intrusive thoughts cannot be resolved by logic or reason. Typical obsessions include excessive concerns about contamination and harm, the need for symmetry or accuracy, and the prohibition of sexual or religious thoughts. [1]

Compulsions: Compulsions are repetitive behaviours or mental acts that a person feels motivated to perform in response to an obsession. The purpose of behaviour is to prevent or reduce distress and a fearful situation. Although compulsion can ease the concern, the session is repeated and the cycle repeats repeatedly. Common constraints include cleaning, repetition, control, order and order, mental constraints, etc. [1]

Definition of OCD:
Obsessive-Compulsive Disorder (OCD) is a common ,chronic and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and behaviours (Compulsions) that he or she feels the urge to repeat over and over [1].
An obsession is defined as an idea, impulse or image which intrude into the conscious mind repeatedly.

3. Classification: ICD 9 [2]

F42.0 Obsessive compulsive disorder
1) F42.0 Predominantly obsessive thoughts or ruminations
2) F42.1 Predominantly compulsive acts
3) F42.2 Mixed Obsessional thoughts and acts
4) F42.8 Other obsessive -compulsive disorders
5) F42.9 obsessive -compulsive disorder, unspecified.

1) F42.0 Predominantly Obsessional Thoughts or Ruminations:
These can be in the form of ideas, thoughts, or impulses to act. They are highly variable in content, but almost always sad for the individual. For example, a woman may be tormented by fear of finally not being able to resist an impulse to kill a child she loves, or by an obscene and emotional-intimate quality, or by repeated mental image. Sometimes ideas are simply useless, involving endless and quasi-philosophical consideration of infinite alternatives. This indeterminate consideration of alternatives is an important element of much of other obsessional confusion and is often linked to an inability to make trivial but necessary decisions in daily life.

2) F42.1 Predominantly Compulsive Acts (Obsessional Rituals)
The majority of compulsive acts are concerned with cleaning (particularly hand-washing) repeated checking to ensure that a potentially dangerous situation has not been allowed to develop, or orderliness and tidiness. Underlying the overt behaviour is a fear, usually of danger either to or caused by the patient, and the ritual act is ineffectual or symbolic attempt to avert that danger. Compulsive ritual act may occupy many hours every day are sometimes associated with marked indecisiveness and slowness. Compulsive ritual acts are less closely associated with depression than obsessional thoughts and are more readily amenable to behavioural therapies.

3) F42.2 Mixed Obsessional Thoughts and Acts:

Most obsessive -compulsive individuals have elements of both obsessional thinking and compulsive behaviour. This subcategory should be used if the two are equally prominent it often the case, but it is useful to specify only one if it is clearly predominant, since thoughts and acts may respond to different treatments.

Aetiology of OCD [3, 4, 13]

4. Biological theories:

a) Neurotransmitters:

- Serotonin: Recent clinical laboratory studies have suggested that changes in brain serotonin.(5-HT) function may contribute to anxiety symptoms and anxiety -type behaviours. Among the anxiety disorders, perhaps the most compelling evidence implicating 5-HT exists for OCD.
- Noradrenaline: OCD patients were found to have higher plasma free 3-methoxy -4-hydroxy -phenyl glycol and plasma norepinephrine levels. The maximum number of binding sites (Bmax) for tritiated clonidine was significant greater in OCD patients than in normal. This pattern of alpha 2-adrenoreceptor status, is different than the patterns in major depression and panic anxiety, Khanna et al found that overall, there was a blunted growth hormone, cortisol and ACTH response to clonidine in OCD.

b) Genetics:

Several investigators from the time of Griesinger (1868) have found evidence to suggest a familial excess of OCD in some families. There is sufficient evidence to suggest that OCD can be transmitted genetically. The strongest evidence for this comes from twin studies. However, the large bulk of subjects with OCD are unlikely to have first -degrees relatives with the same disorder. Their families are likely to have psychiatrically ill individuals than expected.

c) Electrophysiological Studies:

- Electroencephalography: Many of the earlier reports suggested EEG abnormalities in OCD. Temporal lobe spikes and increased theta waves have been reported in sleep EEG of OCD subjects.
- Evoked Potentials: Shagass found higher N60 amplitudes in somatosensory evoked potentials in OCD. Obsessional patients are characterized by reduced amplitudes and decreased latencies of late EP component the role of the frontal lobes in such cognitive functions is implicit and such a dysfunction has been postulated in OCD.

d) Brain Imaging:

- Cranial CT and MRI Scans: The first reported abnormality in cranial CT in OCD was an increase in the ventricular -brain ratio but this was not replicated. Subsequent studies have shown similar results with the caudate nuclei. Earlier reports found non-specific abnormalities on magnetic resonance imaging of the brains in OCD.
- Behavioural Theories: From the learning perspective, obsessions and compulsions are understood as the result of underplay of classical and operant conditioning paradigms. Ranchman explained obsession in the classical conditioning paradigm. The external aversive stimulus interacts with the primed organism. By previous learning, such stimuli acquired specific significance, this thus results in the stimulus gaining more strength, and in sensitization rather than re-habituation. Ritual acts produce relief and thus through negative reinforcement increase the possibility of repetition of the phenomena. Mower's two stage theory postulates that in stage one, a neutral stimulus becomes associated with fear as it occurs with an event, which provokes discomfort. Due to this association, various objects, thoughts, images also become capable of causing discomfort. In stage two, response that reduce anxiety or discomfort are developed and maintained. This theory has been used to explain the role of exposure and response prevention in OCD. Wolpe categorized compulsions as anxiety-elevating and relieving, while the former were thoughts to occur automatically in response to anxiety evoking stimuli, the later were a reaction to anxiety and the act was aimed at temporarily relieving this, Stimulus generalization for obsessions and compulsions has been also proposed.
- Psychodynamic Theories: According to Freud, the anal erotic phase of psychosexual development was responsible for the evolution of anankastic traits to defend against unacceptable anal impulses. With the move towards Ego psychological theory, the conflict was thought to raise due to inadequate mastery of the Oedipal conflict, this resulted in regression to the anal sadistic stage -to avoid anxiety -to which the subject was already predisposed due to difficulties in the anal period of development .This stimulates anal and aggressive impulses, against which defence mechanisms like isolation, undoing, reaction formation, ambivalence, indecisiveness, magical thinking, orderliness, obstinacy and rigidity are used.
- Pandas Syndrome: PANDAS is short "paediatric autoimmune neuropsychiatric disorders associated with streptococcal infections". It describes a group of conditions that can affect children who have had strep infections, such as strep throat or scarlet fever. OCD is one of these conditions.
- Childhood Trauma: Some studies show an association between childhood trauma, such as abuse or neglect and the development of OCD.

5. Risk Factors

- Family History: Having parents or other family members with the disorder can raise your risk of getting OCD.
- Stressful life Events: If you've gone through traumatic or stressful events, your risk may increase. This reaction may cause the intrusive thoughts, rituals and emotional distress seen in OCD.
- Other mental health disorders: OCD may related to other mental health disorders, such as anxiety disorders, depression, substance abuse or tic disorders.

6. Clinical Features of OCD as ICD-10 [3-5]

Obsessive-compulsive disorder usually includes both obsessions and compulsions. But it's also possible to have only obsession symptoms or only compulsion symptoms.

Obsession Symptoms:
OCD obsessions are lasting and unwanted thoughts that keeping coming back or urges or images that are intrusive and cause distress or anxiety. We might try to ignore them or get rid of them by acting based on ritual. These obsessions usually intrude when you are trying to think of or do other things.

Obsessions often have themes, such as,
1) Fear of contamination or dirt
2) Doubting and having a hard some dealing with uncertainty
3) Needing things to be orderly and balanced
4) Aggressive or horrific thoughts about losing control and harming themselves or others
5) Unwanted thoughts, including aggression, or sexual or religious subjects.

Examples of Obsessions symptoms include:
- Fear of being contaminated by touching objects others have touched
- Doubts that you've locked the door or turned off the stove
- Intense stress when objects aren't orderly or facing a certain way
- Images of driving your car into a crowd of people
- Thoughts about shouting obscenities or not acting the right way I public
- Unpleasant sexual images
- Staying away from situation that can cause obsessions, such as shaking hands.
- Fear of making mistakes
- Need for order, neatness, symmetry or perfection
- Fear of causing harm to yourself or someone else.

Compulsion Symptoms [9, 12]
OCD compulsions are repetitive behaviours that you feel driven to do, these repetitive behaviours or mental acts are meant to reduce anxiety related to your obsessions or prevent something bad from happening, but taking part in the compulsions brings no pleasure and may offer only limited relief from anxiety. You may make up rules or rituals to follow that help control your anxiety when you are having obsessive thoughts. These compulsions are beyond reason and often don't relate to the issue they are intended to fix.

As with obsessions, compulsions usually have themes, such as
1) Washing and cleaning
2) Checking
3) Counting
4) Ordering
5) Following a strict routine
6) Demanding reassurance

Examples of compulsions Symptoms include:
- Hand washing until your skin becomes raw
- Checking doors over and over again to make sure they are locked
- Checking the stove over and over again to make sure it's off
- Number rituals such as counting repeatedly
- Arranging things in a very specific way
- Silently repeating a prayer, word or phrase
- Trying to replace a bad thought with a good thought
- Arranging your canned goods to face the same way.
- Collecting or hoarding items that have no personal or financial value

7. Complications [3]

1) Excessive time spent-taking part in ritualistic behaviours
2) Health issues, such as contact dermatitis from frequent hand-washing
3) Having a hard time going to work or school or taking part in social activities
4) Troubled relationship
5) Poor quality of life
6) Thoughts about suicide and behaviour related to suicide.

8. Clinical Assessment [4, 6]

A through medical history and mental status examination are vital in diagnosing the condition, differentiating OCD from other disorders, gauging prognosis, and devising a treatment plan. During the assessment, determining whether the patient is grappling with obsessions, compulsions or both is critical symptoms should also be categorized into the following specific dimensions.
- Contamination: Cleanliness obsessions and cleaning compulsions
- Harmful thoughts: Fears of causing harm and compulsive checking
- Forbidden thoughts: Aggressive, sexual or religious obsessions with corresponding mental rituals, often suggest a worse prognosis.
- Symmetry: Compulsions ex-Repeating, ordering, and counting.

Safety assessment are also conducted to look for immediate risks to the patient or others. Screening for comorbid conditions including depression, bipolar disorder, and other anxiety disorders, should be performed, and the patients past psychiatric and general medical history should be reviewed. All medications, supplements, and known allergies or sensitivities should be obtained also. Furthermore, clinicians should gather pertinent information on the patient's psychosocial background, including familial relationship, stressors and educational history. A family history focusing on OCD and other psychiatric conditions is also obtained to provide a holistic view of the patient's health.

Mental Status Examination:
The mental status examination (MSE) for patients with OCD differ depending upon the severity of symptoms, specific manifestations of the disorder, and any coexisting conditions. The following are some MSE findings that are common during the clinical assessment.

- Appearance and Behaviour: Patients generally present as well-groomed but exhibit visible anxiety. Manifestations of OCD, such as frequent hand washing, checking behaviours, or rearrangement of objects, are often observed during the interview and serve as a diagnostic indicator.
- Psychomotor activity: Individuals are observed engaging in repetitive actions (ex-tapping, checking, or constantly washing their hands). These behaviours are compulsively performed, even when causing visible distress to the patient.
- Speech: While articulation is generally coherent and goal-oriented, intrusive thoughts any periodically disrupt the flow of speech. Depending on the individual, these thoughts may or may not be vocalized during the examination.
- Mood and Affect: Patients usually report feelings of anxiety or distress, and their emotional expression (affect) appears consistent with these reported experiences, often displaying heightened signs of stress.
- Thought Content: Obsessive thoughts differ among patients but commonly resolve around themes like contamination, harm to oneself or others, a quest for symmetry, or distressing sexual or religious beliefs. Compulsions to counteract these obsessions are frequently reported.
- Thought Process: Generally linear and coherent, intrusive, obsessive thoughts intermittently interrupt the thought process. Patients usually acknowledge these thoughts as irrational yet find themselves compelled to respond with corresponding compulsions
- Perceptual Abnormalities: Unlike some other psychiatric disorders, hallucinations or illusions are seldom observed in OCD patients.
- Cognition: Patients typically remain alert and oriented to time, place, and person, overall cognitive function is usually preserved, although sometimes compromised by the pervasive nature of the obsessive thoughts.
- Insight and Judgment: A significant feature in most OCD cases is the preservation of insight. Patients often recognize the irrational nature of their obsessions and compulsions but report feeling powerless to control them. Judgement may specifically falter when resisting the urge to perform compulsive behaviours.

9. Treatment [5–7, 10, 11]

9.1 Psychotherapy

Cognitive behavioural Therapy (CBT) a type of psychotherapy, is effective for many people with OCD. Exposure and response prevention (ERP) a part of CBT therapy, involves exposing you over time to a feared object or obsession, such as dirt, then you learn ways not to do your compulsive rituals. ERP takes effort and practice, but you may enjoy a better quality of life once you learn to manage your obsessions and compulsions.

9.2 Medications

Certain psychiatric medicines can help control the obsessions and compulsions of OCD. Most commonly, antidepressants are tried first.

Antidepressants approved by the food and Drug administration (FDA) to treat OCD include:

- Fluoxetine:(Prozac) for adults and children 7 years and older
- Fluvoxamine (Luvox) for adults and children 8 years an older
- Paroxetine (paxil) for adults only
- Sertraline (Zoloft) for adults and children 6 years and older
- Clomipramine (Anafranil) for adults and children 10 years and older.

9.3 Other Treatment:

- Intensive outpatient and residential treatment programs: Full treatment programs that stress ERP therapy principles may help people with OCD who struggle with being able to function because of hoe serious their symptoms are. These programs usually last several weeks.
- Deep Brain Stimulation (DBS): The FDA has approved DBS to treat OCD in adults ages 18 years and older who don't respond to traditional treatment. DBS involves implanting electrodes within certain areas of your brain. These electrodes produce electrical impulses that may help control impulses that aren't typical. DBS isn't widely available, and it is rarely used.
- Transcranial magnetic Stimulation (TMS): The FDA has approved three TMS devices — Brains-way, Mag-venture and Neuro-star — to treat OCD in adults. These devices are used when traditional treatment hasn't been effective. TMS doesn't require surgery. It uses magnetic fields to stimulate nerve cells in the brain to make symptoms of OCD better. During a TMS session, an electromagnetic coil is placed against your scalp near your for head. The coil delivers a magnetic pulse that stimulates nerve cells in your brain.

9.4 Lifestyle and Home Remedies:

- Consistently apply learned strategies: Collaborate with mental health professional to identify effective techniques for managing symptoms and practice them regularly.
- Adhere to prescribed medications: It is important to take medications as prescribed, even when symptoms improve, to prevent the recurrence of OCD. Discontinuing them without medical guidance may lead to a recurrence of OCD symptoms.
- Monitor for warning signs: Recognizing potential triggers that may exacerbate OCD symptoms is an important aspect of managing the condition, through collaboration with a doctor. Develop a plan to manage symptoms should they reappear.
- Consult before taking additional medications: Consulting an OCD treatment provider before taking any prescription or over-the-counter medications, vitamins, herbal remedies, or supplements is important to avoid potential drug interactions.

9.5 Copping and Support:

- Join a Support Group: Joining a support group allows individuals to connect with others facing similar challenges, offering mutual encouragement and coping strategies.
- Find Healthy Outlets: Engaging in healthy outlets, such as hobbies and recreational activities, provides a constructive way to channel energy. Regular exercise, a balanced diet, and sufficient sleep contribute to overall well-being and symptom management.

9.6 Learn relaxation and stress management [9, 12]

In addition to professional treatment, stress management methods such as meditation, visualization

- Cognitive Behavioural Therapy (CBT): A type of psychotherapy that helps the patient to break down their problems down and face the fears without performing compulsions.
- Exposure and Response Prevention (ERP): a specialised form of CBT, to reduce compulsions gradually.
- Mindfulness-Based Therapy: for managing anxiety and fostering emotional resilience.
- Family Therapy: is used strengthen family support and improve communication.
- Art Therapy and Occupational Therapy: to promote relaxation and enhance coping skills.
- Acceptance and Commitment Therapy (ACT): Helps the patient to learn to accept obsessive thoughts and live a meaningful life.
- Deep Transcranial Magnetic Stimulation (Deep TMS): A non-invasive treatment that uses magnetic fields to regulate neural activity in the brain.
- Stress Management: Techniques like regular exercise, Yoga, Meditation, and deep breathing can help reduce symptoms.
- Support Groups: patient can find support from people who understand what you're going through.
- Ketamine Infusion Therapy: Disrupts neural pathways associated with OCD and can lead to rapid improvements.
- Natural Remedies: Vitamins, and minerals like Vitamin D3, Zinc, Magnesium, and Vitamin B12 may help.
- Lifestyle Modification: this helps the patient integrate beneficial lifestyle changes, such as regular exercise, balanced nutrition, and sleep routines, to support mental health.

10. Conclusion

Obsessive-Compulsive Disorder (OCD) is a complex mental disorder characterized by persistent obsessions and compulsions that cause distress and interfere with daily functioning. Obsessions are intrusive, distressing thoughts or impulses, often revolving around contamination, harm, or the need for symmetry, while compulsions are repetitive behaviours or mental acts performed to alleviate anxiety. The etiology of OCD is multifaceted, involving biological factors such as neurotransmitter imbalances, genetic predisposition, and brain abnormalities, as well as behavioural and psychodynamic theories. Risk factors include family history, stressful life events, and coexisting mental health conditions. Diagnosis relies on a thorough clinical assessment, including medical history, mental status examination, and evaluation of symptom dimensions. Treatment typically involves cognitive-behavioural therapy (CBT), particularly exposure and response prevention (ERP), as well as medications such as selective serotonin reuptake inhibitors (SSRIs). In severe cases, alternative treatments like deep brain stimulation (DBS) or transcranial magnetic stimulation (TMS) may be considered. Lifestyle modifications, stress management techniques, and support groups further contribute to improving the quality of life for individuals with OCD.

References

[1] The National Institute of Mental Health (NIMH) (January 2016). "What is obsessive-compulsive disorder (OCD)?". U.S. National Institutes of Health (NIH). Archived from the original on 23 July 2016. Retrieved 24 July 2016.
[2] Diagnostic and statistical manual of mental disorders: DSM-5 (5th ed.). Washington: American Psychiatric Publishing. 2013. pp. 237–242. ISBN 978-0-89042-555-8.
[3] Angelakis I, Gooding P, Tarrier N, Panagioti M (July 2015). "Suicidality in obsessive compulsive disorder (OCD): a systematic review and meta-analysis". Clinical Psychology Review. 39. Pergamon Press: 1–15. doi:10.1016/j.cpr.2015.03.002. ISSN 0272-7358. PMID 25875222.
[4] Grant JE (August 2014). "Clinical practice: Obsessive-compulsive disorder". The New England Journal of Medicine. 371 (7): 646–653. doi:10.1056/NEJMcp1402176. PMID 25119610.
[5] Veale D, Miles S, Smallcombe N, Ghezai H, Goldacre B, Hodsoll J (November 2014). "Atypical antipsychotic augmentation in SSRI treatment refractory obsessive-compulsive disorder: a systematic review and meta-analysis". BMC Psychiatry. 14: 317. doi:10.1186/s12888-014-0317-5. PMC 4262998. PMID 25432131.
[6] Goodman WK, Grice DE, Lapidus KA, Coffey BJ (September 2014). "Obsessive-compulsive disorder". The Psychiatric Clinics of North America. 37 (3): 257–267. doi:10.1016/j.psc.2014.06.004. PMID 25150561.
[7] Sartorius N, Henderson A, Strotzka H, Lipowski Z, Yu-cun S, You-xin X, et al. "The ICD-10 Classification of Mental and Behavioural Disorders Clinical descriptions and diagnostic guidelines" (PDF). who.int World Health Organization. p. 142. Retrieved 8 August 2023.
[8] "Overview – Obsessive compulsive disorder (OCD)". nhs.uk. 16 February 2021. Retrieved 6 November 2021.
[9] "What Is Obsessive-Compulsive Disorder?". psychiatry.org. Retrieved 6 November 2021.
[10] CDC (2 December 2020). "Obsessive-Compulsive Disorder in Children | CDC". Centers for Disease Control and Prevention. Retrieved 6 November 2021.
[11] Williams MT, Farris SG, Turkheimer E, Pinto A, Ozanick K, Franklin ME, et al. (June 2011). "Myth of the pure obsessional type in obsessive-compulsive disorder". Depression and Anxiety. 28 (6): 495–500.

doi:10.1002/da.20820. PMC 3227121. PMID 21509914.
[12] "What are compulsions? | OCD-UK". Retrieved 5 November 2021.
[13] Thamby A, Khanna S (2019). "The role of personality disorders in obsessive-compulsive disorder". Indian Journal of Psychiatry. 61 (7): S114–S118. doi:10.4103/psychiatry.IndianJPsychiatry_526_18. PMC 6343421. PMID 30745684.

Author Profile

Sister Kulandai Therese received the B.Sc. degree in Nursing from Martha College of Nursing in 2022. She is a nun with over 20 years of services under the Daughters of St. Mary of Providence, Bangalore, India. She is currently a lecturer at T. John College of Nursing, Bangalore. Karnataka, India.