Explanatory models for obsessive compulsive disorder

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The researchers have fabricated evidence for the involvement of biological factors for causing obsessive compulsive disorder through the various studies (Stein, 2002). According to biological perspective, the symptoms of OCD occur due to the impaired functioning in neurochemistry, neuroanatomy and/or neurofunctioning. But still there remains considerable disagreement in the discipline about the assumed biological mechanisms involved in the etiology of OCD.

Some researchers initially advocated that OCD results from low levels of serotonin (Yaryura-Tobias, 1977). Conversely, more recently, researchers have put forward that OCD is associated with increased serotonergic activity (Dolberg et. al., 1996; Murphy et. al., 1996; Pogarell, Homann, Popperl, et. al., 2003). However it is also turning out to be apparent that dysfunction in

serotonergic systems cannot fully explain this complex disorder. Other neurotransmitters also seem to be involved in the development of OCD (Baxter et. al., 2000; Hollander et. al., 1992).

A discrepancy has also been found regarding the role of structure of brain in OCD. The primitive researches indicated that the structural brain abnormality lying behind obsessive compulsive disorder was limited to basal ganglia. With the help of imaging technology, these studies reported lesions and atrophies in the basal ganglia structures of patients with compulsive behaviors (Hoehn-Saric & Greenberg, 1997). On the other hand many other investigations confirmed that the structural brain abnormalities in OCD were more widely distributed than previously thought. For instance Garber and colleagues found abnormalities in frontal white matter, implicating frontal lobe and anterior cingulate involvement in OCD symptoms (Garber, Ananth, Chiu, Griswold, & Oldendorf, 1989). Regardless of some support for abnormal brain structure in patients with OCD, approximately 40% of controlled studies have failed to find a major difference between OCD subjects and controls (Cottraux & Gerard, 1998). Such incongruity in the literature has consequently confronted the view that OCD necessarily involves differences in brain anatomy.

The disordered brain functioning has also been a focus in causing obsessive compulsive symptoms. The researches indicate patients with OCD reflect impairments in functions linked to the orbito-frontal and basal ganglia regions (Hoehn-Saric & Greenberg, 1997).

Genetic Model of OCD

The evidence for the genetic transmission of OCD is ambivalent. The familial tendency of OCD has been observed since the 1930s using genetic studies of OCD. These included the studies of twins, family history, family studies, segregation, and association studies, and revealed that some specific genes have an effect on the development of OCD (Wolff, 2000). Carey and Gottesman found in their study in 1981, 87% concordance rate of obsessive symptoms and tendencies among monozygotic twins and 47% in dyzygotic twins. Riddle et. al. reported that 71% of the clinically referred children with OCD had a parent with either OCD or OC symptoms. Bellodi and collegues concluded that the morbidity risk for OCD in patients' families accounted for 3. 4%. (Bellodi, Sciuto, Diaferia, Ronchi, & Smeraldi, 1992)

On the other hand, other researches have obtained no support for the genetic transmission of OCD. For instance, Rosenberg (1967) found that only two of 547 relatives of 144 obsessionals had OCD. The relatives of 50 OCD subjects and the relatives of 50 controls were assessed by McKeon and Murray in 1987 and no difference in the rates of OCD were found among the both groups. Similarly Black and colleagues were unable to find multiple number of OCD or OCD symptoms in relatives or parents of OCD patients (Black, Noyes, Goldstein, & Blum, 1992), compared to the relatives of parents of normal controls.

The different methodologies employed in these researches have contributed to discrepant findings and turn out comparisons complicated. Therefore, it is probable that high rates of concordance in twins and families are due to

environmental and rearing practices, rather than genetic influences (Jakes, 1996).

Behavioral Model of OCD

The dominant behavioral view of obsessive disorder is the conditioning mechanisms which are claimed to be involved in the acquisition and maintenance of Obsessive compulsive disorder (Dollard & Miller, 1950; Mowrer, 1960; Rachman & Hodgson, 1980). Classical conditioning is associated with the acquisition of OCD, whereas operant conditioning processes are believed to lie beneath the maintenance of OCD (Rachman & Hodgson, 1980; Teasdale, 1974).

The maintenance of OCD lean on operant conditioning, where the individual puts his efforts to keep away from distress or danger by avoiding stimuli related to the thought, by suppressing the thought itself, or by engaging in compulsive rituals. The behavioral theory of OCD is precious as it grants a theoretical justification for the most effective intervention to date for OCD which is Exposure and Response Prevention (Franklin & Foa, 1998).

Even though the behavioral model of OCD seems satisfactory in explaining the acquisition and maintenance of symptoms of obsessive compulsive disorder, it has also been criticized on a few grounds. According to Salkovskis (1998), the behavioral perspective fails to differentiate between OCD and different other anxiety disorders. The same two conditioning processes in the acquisition and maintenance of fear have been implicated in all anxiety based problems. As a result, the model does not account for why some individuals develop intrusive thoughts and compulsions, while others develop

different symptoms (e. g., phobic avoidance). In short, the behavioral model does not illuminate features involved in the susceptibility for Obsessive compulsive disorders. Moreover it does not describe that why do individuals respond differently to stimuli despite similar conditioning experiences? For example, individuals may respond differently to intrusions that occur in association with aversive stimuli.

Cognitive Model of OCD

The cognitive model of OCD encloses obsessions and compulsions as products of catastrophic misinterpretations of one's thoughts, images or impulses (Rachman, 2002). According to the cognitive perspective, appraisals (interpretations) and avoidance behaviours (e. g., neutralizations) are collaboratively engrossed in the development and maintenance of OCD symptoms. Salkovskis (1985) argues that individuals with OCD appraise automatically occurring interfering thoughts as posing a threat for which the individual is personally responsible. Rachman (1997) highlights in his studies, that the patients with OCD interpret disturbing thoughts as having negative implications for moral standards or real world outcomes. Consequently, compulsions are performed in order to satisfy the sense of threat that results from these appraisals.

According to cognitive theorists such as Beck (1967), Salkovskis (1985) and Rachman (1997), such interpretations are influenced by beliefs and assumptions about the self, world and others, which in turn are shaped by early life experiences and relationships. A range of beliefs and assumptions have been nominated as guiding these appraisals. According to Wollersheim and McFall (1978) the individuals with OCD overestimate the significance of

upholding high standards with the intention to avert criticism and punishment. The unacceptability of having repugnant thoughts and the extent to which one could influence real-world outcomes by magical rituals.

Psychodynamic Models of OCD

Psychoanalysis and psychodynamically oriented theories for obsessions and compulsions have raised a number of interesting hypotheses in the area.

According to Freud (1987)obsessions and compulsions result from instinctual forces, sexual or aggressive that is not under control because of overly harsh toilet training. The person is thus fixated at that stage may become compulsively neat, clean and orderly. Freud (1909/1987) also argued that the obsessions grow in opposition to the circumstances of superstitious beliefs and cravings for certainty. Freud projected that individuals with obsessions overrate the supremacy of thoughts, feeling and wishes, and demonstrate a preference for dwelling on unresolved issues. Freud believed that obsessions and compulsions signified the patient′s defences against unconscious aggressive impulses and death wishes towards the patient′s parent. Similarly, Freud viewed compulsions as a defence against unwanted fantasies and impulses.

According to Alfred Adler (1931), obsessive compulsive disorder results due to feelings of incompetence. He believed that when children are kept from development a sense of competence by doting or excessive dominating parents, they developed inferiority complex and may unconsciously adopt compulsive rituals in order to carve out a domain in which they exert control and feel proficient (Davison & Neale, 2001).

Nemiah and Uhde (1989) observed that, from a psychoanalytic approach, three most important psychological defense mechanisms verify the form and quality of obsessive-compulsive symptoms and character traits which are isolation, undoing, and reaction formation.

Isolation

The role of defense mechanism isolation is to safeguards a person from anxiety-provoking impulses. In normal situations, an individual faces mutually the affect and the imagery of overloaded emotional ideas consciously, whether it is a fantasy or the recollection of an event. Whenever isolation occurs, the affect and the impulse from which it originates are disconnected from the ideational component and thrusted out of consciousness. If isolation is totally thriving, the impulse and associated affect related to it are completely repressed, and the patient is intentionally conscious of only the affectless thought which is associated to it. Obsessive compulsive patients go through a partial knowledge of the impulse without completely being familiar with its meaning or importance. The people with OCD may be obsessed with images and thoughts; the power from the partially repressed impulse provide the thoughts their compelling feature.

Undoing

Nemiah and Uhde (1989) noted that, another defense mechanism active for Obsessive Compulsive disorder was undoing. Since the word indicate, undoing is associates to a compulsive act that is carried out in an effort to stop or undo the consequences that the patient unreasonably foresee from a threatening obsession.

Reaction formation

Reaction formation, a third defense mechanism intimately connected with OCD, according to Nemiah and Uhde (1989), results in the development of character traits rather than symptoms. Reaction formation involves evident patterns of behavior and consciously experienced feelings and thoughts that are particularly contrary of the underlying impulses. Frequently such behaviors appear to be extremely overstated and occasionally pretty inappropriate. Reaction formation is considered to be accountable for many of the personality traits which are related features of obsessive-compulsive personality disorder.

Family Theories of OCD

Researches indicate that the parenting practices play a vital role in the development of the OCD symptoms. The parenting practices and attitudes characterized by overprotection, over-critical features, lack of emotional warmth and lack of caring have variously been implicated in the development of OCD (Cavedo & Parker, 1994; Rachman & De Silva, 1978). There is evidence that OCD patients think of their parents as overly rejecting, protective, emotionally distant (Chambless, Gillis, Tran, & Steketee, 1996; Frost et al., 1994; Turgeon, O'Connor, Marchand, & Freeston, 2002). It was argued by Guidano and Liotti (1983) that individuals, who experience confusing and ambivalent prototype of attachments with their parents, grow up with the risk for obsessional illnesses.

Families acquire OCD symptoms in many ways and to diverse levels. According to Shafran and colleagues (1995) through concern, the load of care and distress at their limited ability to help the person with OCD the

other family members also get hold of the obsessive and compulsive patterns. Calvocoressi et al. (1999) advocates that a number of times family members get involved in rituals of the patients with OCD. Similarly they may possibly respond to repetitive queries and requirements for reassurance. This kind of help for the patient is eventually obstructive as family members are over-involved in sustaining the disorder in some ways.

Socio-cultural Theories of OCD

Horwath & Weissman (2000) state that research investigations from different cultures disclose similar prevalence rates and uniformity in the types, forms and rituals of obsessions and compulsions. According to Fontenelle et. al. (2004) socio-cultural factors shape the expression of OCD in some ways. For instance, the religious obsessions and compulsions indicate the religious viewpoint of the individual and conceivably of the society. Such patterns are usually established on mainly some firm rather extreme collections of beliefs or practices which are not extensively common among the other members of the society (Tek & Ulug, 2001).