Ocd research paper

Science

Obsessive-Compulsive Disorder OCD stands for obsessive-compulsive disorder. An individual with OCD tends to worry about many different things. On average, one out of fifty adults currently suffer from this disorder, and twice that many have had it at some point in their lives. When worries, doubts, or superstitious beliefs become excessive then a diagnosis of OCD is made. With OCD it is thought that the brain gets stuck on a particular thought or urge and just can't let go. Most often people with OCD describe the symptoms as a case of mental hiccups that won't go away. This causes problems in information processing.

OCD was generally thought as untreatable until the arrival of modern medications and cognitive behavior therapy. Most people continue to suffer even though they had years of ineffective psychotherapy. Today treatments tend to help most people with OCD. OCD is not completely curable but is somewhat treatable. OCD is a potentially disabling condition that may persist throughout a person's life and get worse without treatment. An individual with OCD becomes trapped in a pattern of repetitive thoughts and behaviors that are senseless and distressing but are extremely powerful and hard to overcome.

OCD can occur in cases from mild to severe, but if left untreated can destroy a persons life and capacity to function at work, school, and even at home. Some of the worries and rituals can get out of control. An individual life becomes dominated by thoughts and behaviors they know make absolutely no sense but they are powerless to control. People with OCD tend to fear uncertainty; these people are plagued by persistent and recurring thoughts

or " obsessions" that they find very disturbing. These thoughts usually reflect exaggeratedanxietyor fears that have no basis on reality.

A person who suffers from OCD has constant doubts about their behaviors and constantly seeks assurance from other people. Many people who suffer from this disorder feel compelled to perform certain rituals or routines to help relieve the anxiety caused by their " obsessions", however the relief is only temporary. Some rituals or " obsessions" include cleaning, checking, repeating, slowness, and hoarding. Usually an individual has both obsessions and compulsions, though sometimes they have only one or the other.

A person with OCD usually wants everything around them to be perfect. {What is 1}? Most common symptoms of OCD go along with a certain compulsion for instance: A need to tell, ask, or confess goes along with praying. A need to have things " just so" goes along with hoarding or saving. Forbidden thoughts equals arranging. Excessive religious or moral doubt = counting. Intrusive sexual thoughts or urges cause touching. Imagining losing control or aggressive urges causes checking. Imagining having harmed ones self or others creates the symptom of repeating.

Fear of contamination or germs causes constant washing. Compulsions are intrusive thoughts, impulses, and images that feel out of control and occur over and over again. A sufferer does not want to have these ideas and knows that they don't make any sense but find them intrusive and disturbing. A person with OCD may be obsessed with the idea they are contaminated or may contaminate someone else and worry excessively about dirt and germs. This person could also have an intense fear that they harmed someone else although they usually know it is not realistic. {What 3}

Some of the most common obsessions of OCD in children are extreme concern with order, concern that a task or assignment has been done poorly or incorrectly, concern with certain sounds or images, fear that a disaster will occur, there is also the fear of AIDS, fear of getting dirty, fear of losing important things, recurring thoughts, and a fear of saying something wrong. Checking compulsions are rituals that are precipitated by fear of harm to oneself or others and this includes the checking of doors, locks, heaters, alarms, faucets, switches, and other objects that could be a threat.

This can create problems for the learning of a child. For example while getting ready for school a child may check his or her books several times to make sure they are all there even to the point where the child is late for school. Once the child is in school they may call to return home and check their books once more. These rituals may also interfere with the completion of homework. This could make a child work late at night to complete an assignment that could have taken ten minutes to complete. Repeating compulsions are rituals in which some one repeats a certain action over and over again.

These rituals can in some cases be anxiety driven and in other cases have to be done " just so". For instance a person might walk backward and forward or get up and down from a chair many times until the ritual is performed " just right". These rituals are also connected with counting rituals. In children the rituals can assume many forms in the classroom. This could lead to many repeated questions because the child may need to remember or know something. On written assignments the student could endlessly cross out, trace, or rewrite letters or words.

Lockerscan also cause a problem because the combination may need to be repeated several times till it feels right. Note taking is most likely impossible because the student is compelled to take every word down. Computer scored tests are a nightmare because the student has to fill in the circles perfectly. Uncomfortable feelings such as fear, disgust, doubt, or a sensation that things have to be " just so" usually accompany obsessions. A person tries to make their obsessions go away by performing certain compulsive rituals. These compulsions are acts that an individual may perform repeatedly, often according to certain " rules".

OCD symptoms do not give a person pleasure but a sense of temporary relief for a short period of time. The relief is only temporary and the discomfort always comes back. These relieve make up a lot of time and interfere with a person's social life and relationships. The less common form of OCD is hoarding which is the excessive saving of typically worthless items. A most commonly thought form of OCD is contamination. This is the awareness of germs, disease, or the presence of dirt that evokes a sense of threat and an incredible inspiration to reduce the presence of contamination.

The compulsion of contamination involves a cleaning response such as hand washing and chronic cleaning. {Steven1} Another common form of OCD is checking. Checking involves door locks, lights, switches, faucets, stoves, or items left unchecked that might pose a threat to ones well being or the well being of others. It is not uncommon for people to check items between 10 to 100 times a day. The impulse to recheck can remain until the person experiences a reduction in tension despite the realization that the item is secure.

One other less common form of OCD is ordering in which a person feels compelled to place items in a designated spot in order. Although contamination fears frequently lead to excessive washing they can also have the opposite affect, shoes may be untied, teeth unbrushed, clothing may be slovenly and hair may be dirty. In these cases, fear of contamination of personal objects or body parts leads to the individuals’ refusal to touch them. A combination of excessive hand washing and sloppiness in other areas of grooming had even been reported. Obsessions revolving around a need for symmetry may result in compulsive arranging.

Children who engage in symmetry-related rituals may also feel compelled to have both sides of their bodies identical. For instance a child my spend an inordinate amount of time tying and retying shoelaces so that each side of the bow is perfectly even or " balanced". Symmetry rituals may consist of taking steps that are identical in length or speaking with equalstresson each syllable. In a classroom, symmetry rituals may be seen in the student's compelling need for order. Books on a shelf, items on a desk, or problems on a page must be arranged in a precise manner so that they can appear symmetrical to the student.

Most people recognize at some point that their obsessions are not just worries about real problems but are coming from their minds. Compulsions are excessive or unreasonable but the sufferer has to perform them. OCD poor insight is an individual that not recognize that their beliefs and actions are unreasonable and unreal. Extreme severe distress tends to happen when the symptoms wax and ware over time. OCD symptoms can start at any age

from as early as preschool too as late as adulthood. 1/3 of 1/2 of adult sufferers said that their symptoms started during theirchildhood.

On an average people spend 9 years seeking a diagnosis and see up to 3 to 4 doctors. Studies also show that it takes an average 17 years from the time OCD begins for an individual to find appropriate treatment. {What 3} OCD may be under diagnosed and untreated for a number of reasons. People with OCD may be secretive about their symptoms or lack insight on the illness. Many healthcare providers are not familiar with the symptoms and are not trained to provide treatment. Some people may also not have access to treatment resources. This is unfortunate since early diagnoses and proper treatment can help an individual.

Research suggests genes do play a role in development of the disorder yet no specific genes have been found for OCD. Childhood onset tends to run in thefamily. An increasing risk for a child getting OCD is if the parent has it. When OCD runs in families it seems to be inherited but not the specific symptoms. One example is if a child has checking rituals his mother might wash excessively. There is no single proven cause for OCD. Research suggests that OCD could involve problems incommunicationbetween the brain and deeper structures although this is not proven. what 4} For many years only a small minority of healthcare professionals patients had OCD there for it was thought to be rare. OCD went unrecognized often because many of those afflicted with it kept their repetitive thoughts a secret and failed to seek treatment. This led to the underestimate of the number of people with the illness. {obsessions 1} In approximately 80% of all cases, people performing the rituals are painfully aware that their behavior is

unreasonable and irrational. OCD is an anxiety disorder the thought associated with OCD is bizarre.

The thoughts associated with OCD are recurrent obsessions that create an awareness of alarm or threat. Obsessions can take form of a threat or physical alarm to oneself or others. People typically engage in some avoidance or escape response in reaction to the obsessive threat. There are three main branches of OCD. The most common and well-known branch of OCD is known as OC where the undoing response generally involves some overt behavior. The next branch of OCD is purely obsess ional this involves the escape or avoidance of noxious and unwanted thoughts.

There are a number of treatment strategies, which are specific to obsessive problems. For example, motivations neutralizing behavior and other counter-productive strategies, increasing selective attention and increased negative mood. These serve to maintain the negative beliefs and therefore the obsessive-compulsive problem. Most recently developments in cognitive therapy suggest that the key to understanding obsession problems lies in the way the intrusive thoughts, images, impulses and doubts are interpreted. The general and specific aspects of cognitive-behavioral treatment are described.

The important negative interpretations usually include the idea that a person's actions can result in harm to onset to others. Thisresponsibilityinterpretation has several consequences. { steven 1} OCD can change and affect a person’s life in many ways sometimes alienating them from their friends and family. Many sufferers with OCD are never diagnosed because they are so secretive about their symptoms. They are

afraid to let people know and are even embarrassed about their compulsive reactions. It is a fact that approximately one million children and adolescents in the United States alone suffer from OCD.

This means that 3 to 5 children in an average elementary school and 20 teenagers in a large high school are currently suffering. OCD affects adolescents during an important time of social development. Schoolwork, homework, and friendships are affected most often. Most children are to young to realize that there obsessions and compulsions are unusual. Adolescents are embarrassed because they don't want to be different from other people and they worry uncontrollably about their behavior. These adolescents usually hide their rituals in front of friends at school or at home and become mentally exhausted and strained.

Children and adolescents that suffer from OCD are different from adults because they express their disorder in special ways. Young children often say their rituals are silly. Young children's OCD is never really recognized by their parents until they are about 3 or 4 sometimes even older. To get a proper diagnosis the child should be brought to adoctoror psychiatrist. While a child is at school they usually erase and redo their assignments, which usually results in late schoolwork. Classroom concentration is usually limited because a child is obsessing about their fears and rituals.

Parents should tell a child'steacherabout the OCD and may ask for occasional progress reports. OCD is not contagious and parents are often blamed for the disorder they are said to have parental perfections, inappropriate toilet training, or even under parenting. The cause for OCD is neurobiological. Although life events can also aid in the onset of OCD. Children's OCD is often

said to be started by a death of a loved one, adivorce, moving to a new location, or unhappiness with changes in school. Approximately 80 percent of children and adolescents with OCD at some point during their illness will develop a washing or cleaning ritual.

The most common compulsion is hand washing. An individual may feel compelled to wash their hands extensively and according to a self-prescribed manner for minutes or hours at a time. Other individuals may be less thorough about washing or cleaning but may engage in the act a number of times a day sometimes even hundreds. During school these rituals may manifest themselves in the school setting as subtle behaviors not obviously or immediately related to washing or cleaning. The student’s teacher should be alert if the student frequently excuses himself or herself from the classroom under voiding or guise.

This child could actually be seeking a private area in which to carry out the cleaning rituals. Another sign is the presence of dry, red, chapped, cracked, or even bleeding hands. Bleeding hands are a result of washing with strong cleaning agents such as " Mr. Clean" to free themselves of " contaminants". OCD sufferers usually experience obsessional thoughts that lead to compulsive avoidance in these cases, individuals may go to great lengths to avoid objects, substances, or situations that are capable of triggering fear or discomfort.

For example, fear of contamination may result in the avoiding of objects usually found in the classroom, things like paint, glue, paste, clay, tape, and ink. A child may even inappropriately cover their hands with clothing or gloves or may use facial tissue, shirts, or shirt cuffs to open doors or turn on

faucets. A student with an obsessive fear of harm may avoid using scissors or other sharp tools in the classroom. A child may even circumvent the use of a certain doorway because a passage through that entry may trigger a repeating ritual.

Children and adolescents with OCD may also engage in compulsive reassurance seeking. In the school setting, they may continually ask teachers or other school personnel for reassurance that there for example are no germs on the drinking fountain or that they have not made any errors on a page. Although reassurance may serve to allay the anxiety or discomfort that frequently accompanies their fears the relief is often short lived, different situations typically arise in the classroom that pose new fears or discomfort for the student.

Number obsessions are typically common among young boys. Only certain numbers are " safe" other numbers are " bad". An obsession with a particular number may result in a child's having to repeat an action a given number of times or having to repeatedly count to a particular number. Some children with strong religious ties have an obsessive fear that they are doing something evil. This symptom of OCD is called " scrupulosity" and causes an individual to tell themselves that they constantly commit sins, and they must pray constantly or find ways to condone their imagined sins.

Members of the catholic religion who suffer from this may go to confession many times a week. Some individuals create elaborate systems to avoid certain thoughts, memories, or actions, or to replace or equalize " sinful" thoughts with pure good ones. One of the most reported obsessions in youth with OCD is a fear of contamination. This fear may center on a concern with

germs, dirt, ink, paint, excrement, body secretions, blood, chemicals, and other substances. Recently, an increase in obsessions with AIDS had also been witnessed.

Preoccupation with contamination may lead to the avoidance of suspected contaminants or constant findings in studies such as testing the effectiveness of different therapies; strongly suggest that it is the working alliance or bond between therapist and patient, which is paramount to therapeutic success. Interpersonal aspects of treatment such as 1. comfort 2. confidence and 3. a true commitment from both patient and therapist make a great deal of difference in fostering an atmosphere of collaboration. To be successful both the patient and the therapist need to bring their fullest devotion to the explicit and implicit contract of therapy.

By saying this it means that at the end of each session both parties need to come to an agreement of the next week's challenges. The patient must except the responsibility and be willing to participate in his or her challenges. Clients can choose to share the challenges of this therapy with an experienced partner or they can choose to decline. The principles of this therapy focus on fostering a sense of therapeutic independence on the part of the client. Equally important to training, knowledge, experience, and credentials are understanding, compassion and warmth.

Most often the cognitive-behaviorist believes that self-disclosure is a healthy part of any relationship, including a therapeutic one. Therefore when a client answers questions about themselves it is considered a natural and healthy part of the therapeutic exchange. {steven phillipson 1} The basic premise of this therapy is based on the belief that at the heart ofdepressionexist

distorted and irrational thinking patterns. Such patterns revolve around our automatic reactions toward life circumstances, which create upsetting emotional consequences.

CBT was developed to assist patients to respond rationally to automatic irrational thoughts. Here automatic thoughts are said to be mental reflexive reactions to upsetting events. Typically, the approach teaches people to learn to identify our reflexive reactions or " beliefs" that occur as a consequence to upsetting events, that are responsible for the periodic upset we experience. Traditional therapist that specialize in CBT focus on teaching clients to substitute rational thinking for automatic irrational thinking. {steven phillipson 2}

Basic CBT believes that within all of us exist irrational ideas. This therapeutic intervention is based on therapists' faith in our ability to learn how to sort out the difference between being rational and irrational. At the heart of learning is the belief that we learn from society, family, and religion how to think in dysfunctional and irrational ways. Traditional CBT for patients suffering with OCD is therefore likely to be counter productive toward achieving a beneficial therapeutic outcome. This approach assumes that persons are reacting irrationally to a rationally safe situation.

The problem is that the majority of OCD patients are aware that what they are doing is bizarre and irrational. Most can even predict that the risk of danger is infinitesimal. Yet they feel overwhelmingly compelled to act out some escape response. Therefore using traditional CBT: activating event, automatic thought, emotional reaction, and rational response would be futile. Traditional CBT was developed as a treatment for depression. The two basic

components entail, 1. the behind the scenes strategizing and 2. the front line conflict.

It is very important not to mix up the appropriate application of these two separate strategies when dealing with OCD. The manner in which one conceptualizes a battle and the behavior exerted in fighting it, are very different. {steven phillipson 3} Cognitive therapy for OCD predominantly focuses on the two mentioned aspects of this disorder. The first aspect initially involves having sufferers develop a healthy and informed understanding of how the mechanisms of OCD operate. This focus will be referred to as cognitive conceptualization.

Cognitive conceptualization includes having the sufferer separate themselves from the emotional or moral implications of what the disorder seems to represent. Many people who suffer from the purely obsessional form of this condition and responsibility experience tremendous amounts of guilt and shame for having these thoughts or being responsible for the wellbeing of others. Also involved with the first aspect is having clients appreciate that giving in to a ritual or embracing the risk of the obsession, requires making a series of genuine choices and are not pre-programmed reflexive reactions.

Critical aspects of this focus involve reshaping one's response set to the risk. This involves concentrating on one's relationship with their condition as that of making choices in the matter of giving in the ritual, or not. This viewpoint is in difference to perceiving the reaction to cognitive threats as obligatory or as having no choice in the matter. In practice this translates into having patients reframe their disposition from, " I had to" to " I chose to".

Research has clearly showed that acknowledging our choice in the matter of facing difficult life challenges increases one's tolerance toadversity. Consistently studies have demonstrated that our ability to tolerate pain is greatly increased as we acknowledge our choice in relation to the decision to seek relief or to tolerate the discomfort. As our perceptible sense of control increases so does our willingness to tolerate discomfort. A minor but crucial aspect of cognitive-conceptualization involves educating people about the actual risks pertaining to their specific concerns.

Unfortunately medicalsciencedoesn't offer total certainty. Therefore telling someone that the chances of getting AIDS from a door knob is slim at best, does little to take away the general concern. Some people claim to have been guided by their disorder for so long that they have forgotten their real instincts. In addition, becoming informed that people who spike about being a danger to others rarely actually do damaging things or that person with anxiety disorders almost by no means develops schizophrenia might educate, but rarely provides lasting relief. Steven Phillipson 4} Cognitive-management is the second goal of CT; this involves teaching individuals to respond to obsessive threats in a way that there is little to no debate in response to being spiked. The main goal is to reduce conflict or mental escape in formulating a response to the upsetting thought. The end product is referred to as habituation. Principles are also included in cognitive-management. These principles enhance greater levels of tolerance toward the physical discomfort, generated by the anxiety.

The principles include making space for the discomfort and looking upon it as something to be managed effectively, rather that just achieving a period of

relief. The search to eliminate the spike is more than likely the greatest cognitive misconceptualization that people bring to the therapeutic process. Eventually the goal of CT for OCD is to manage he spike effectively, not to focus on its existence or disappearance. The same thing could be said about the experience of anxiety. Tolerating anxiety focuses on developing room for the experience.

Developing room for its presence enables the brain to focus on other information. Cognitive conceptualization focuses on helping take out a sense of culpability, guilt and shame, which is pervasive among obsessive-compulsive sufferers. To access the ideas andphilosophyof cognitive-conceptualization in the midst of the challenge would be unadvised because it would tend to be reassurance oriented. The goal for later on in the treatment is instructive in aiding a person's respond effectively to the cognitive prompt of the danger with the least resistance, which thereby allows habituation.

Creating an aggressive disposition toward a challenge is tremendously advantageous toward a successful recovery. Aggressiveness is defined as actively looking for anxiety provoking challenges. Paradoxically, when a person seeks an anxiety provoking challenge there tends to be a greater likelihood that experiencing reduced levels of anxiety is achieved. This comes out due to changing the condition's momentum from endless escape to approach. " As we seek challenges there is less likelihood of finding them". Cognitive therapy for OCD has two main applications 1. o help people understand the guidelines of anxiety disorders overall plan 2. to provide specific suggestions in response to the moment of being challenged by

awareness that there is some imminent danger. Cognitive principles to assist sufferers develop a healthy disposition in the direction of their anxiety is The statement " within the question lies the answer" proposes that when confronted with a seemingly sincere risk, relying on the consciousness that there is doubt and therefore making the strength of mind to receive the possibility will get rid of a enormous quantity of difficulty solving. steven phillipson 6} The ultimate aspect of cognitive management entails deliberately creating the consciousness and nature of the chance while engaging in the uncovering exercise. This strategy suggests that combining the behavior a compulsive act with a self-talk enhances the impact of an uncovering exercise. Making the choice to put up with the risk tends to close down the brain's natural propensity to alert its host, through physical uneasiness and cognitive warnings, that you should feel unpleasant until the danger is removed.

Overall CT involves providing a sufferer with specific responses to the spikes and educating them about the distinction between having these concerns and separating one's identity from the topics of the condition and highlighting general strategies which facilitate anxiety management. This goes to say that providing reassurances and attempting to educate the sufferer about the truly limited risks involved in the spikes is counterproductive and alienating. {steven phillipson 7} lead to excessive washing.