Obsessive–Compulsive Disorder: Breaking the Cycle of Rituals

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Obsessive-compulsive disorder (OCD) is an anxiety disorder characterized by intrusive thoughts that produce uneasiness, apprehension, fear, or worry, by repetitive behaviors aimed at reducing the associated anxiety, or by a combination of such obsessions and compulsions. Symptoms of the disorder include excessive washing or cleaning; repeated checking; extreme hoarding; preoccupation with sexual, violent or religious thoughts; aversion to particular numbers; and nervous rituals, such as opening and closing a door a certain number of times before entering or leaving a room. These symptoms can be alienating and time-consuming, and often cause severe emotional and financial distress. The acts of those who have OCD may appear paranoid and potentially psychotic. However, OCD sufferers generally recognize their obsessions and compulsions as irrational, and may become further distressed by this realization.

OCD is the fourth most common mental disorder, and is diagnosed nearly as often as asthma and diabetes mellitus. In the United States, one in 50 adults suffers from OCD. Obsessive-compulsive disorder affects children and adolescents as well as adults. Roughly one third to one half of adults with OCD report a childhood onset of the disorder, suggesting the continuum of anxiety disorders across the life span. The phrase "obsessive-compulsive" has become part of the English lexicon, and is often used in an informal or caricatured manner to describe someone who is excessively meticulous, perfectionistic, absorbed, or otherwise fixated. Although these signs are present in OCD, a person who exhibits them does not necessarily have OCD, and may instead have obsessive-compulsive personality disorder (OCPD), an autism spectrum disorder, or no clinical condition. Multiple psychological and biological factors may be involved in causing obsessive-compulsive syndromes. Standardized rating scales such as Yale-Brown Obsessive Compulsive Scale can be used to assess the severity of OCD symptoms.

Signs and symptoms

Obsessions

Obsessions are thoughts that recur and persist despite efforts to ignore or confront them. People with OCD frequently perform tasks, or compulsions, to seek relief from obsession-related anxiety. Within and among individuals, the initial obsessions, or intrusive thoughts, vary in their clarity and vividness. A relatively vague obsession could involve a general sense of disarray or tension accompanied by a belief that life cannot proceed as normal while the imbalance remains. A more intense obsession could be a preoccupation with the thought or image of someone close to them dying. Other obsessions concern the possibility that someone or something other than oneself--such as God, the Devil, or disease--will harm either the person with OCD or the people or things that the person cares about. Other individuals with OCD may experience the sensation of invisible protrusions emanating from their bodies, or have the feeling that inanimate objects are ensouled.

Some people with OCD experience sexual obsessions that may involve intrusive thoughts or

images of "kissing, touching, fondling, oral sex, anal sex, intercourse, incest and rape" with "strangers, acquaintances, parents, children, family members, friends, coworkers, animals and religious figures", and can include "heterosexual or homosexual content" with persons of any age. As with other intrusive, unpleasant thoughts or images, most "normal" people have some disquieting sexual thoughts at times, but people with OCD may attach extraordinary significance to the thoughts. For example, obsessive fears about sexual orientation can appear to the person with OCD, and even to those around them, as a crisis of sexual identity. Furthermore, the doubt that accompanies OCD leads to uncertainty regarding whether one might act on the troubling thoughts, resulting in self-criticism or self-loathing.

People with OCD understand that their notions do not correspond with reality; however, they feel that they must act as though their notions are correct. For example, an individual who engages in compulsive hoarding might be inclined to treat inorganic matter as if it had the sentience or rights of living organisms, while accepting that such behavior is irrational on a more intellectual level. In severe OCD, obsessions can shift into delusions when resistance to the obsession is abandoned and insight into its senselessness is lost. (Insel and Akiskal (1986))

Compulsions

Some people with OCD perform compulsive rituals because they inexplicably feel they have to, others act compulsively so as to mitigate the anxiety that stems from particular obsessive thoughts. The person might feel that these actions somehow either will prevent a dreaded event from occurring, or will push the event from their thoughts. In any case, the individual's reasoning is so idiosyncratic or distorted that it results in significant distress for the individual with OCD or for those around them. Excessive skin picking (i.e., dermatillomania) or hair plucking (i.e., trichotillomania) and nail biting (i.e., onychophagia) are all on the Obsessive-Compulsive Spectrum. Individuals with OCD are aware that their thoughts and behavior are not rational, but they feel bound to comply with them to fend off feelings of panic or dread.

Some common compulsions include counting specific things (such as footsteps) or in specific ways (for instance, by intervals of two) and doing other repetitive actions, often with atypical sensitivity to numbers or patterns. People might repeatedly wash their hands or clear their throats, make sure certain items are in a straight line, repeatedly check that their parked cars have been locked before leaving them, constantly organize in a certain way, turn lights on and off, keep doors closed at all times, touch objects a certain number of times before exiting a room, walk in a certain routine way like only stepping on a certain color of tile, or have a routine for using stairs, such as always finishing a flight on the same foot.

People rely on compulsions as an escape from their obsessive thoughts; however, they are aware that the relief is only temporary, that the intrusive thoughts will soon return. Some people use

compulsions to avoid situations that may trigger their obsessions. Although some people do certain things over and over again, they do not necessarily perform these actions compulsively. For example, bedtime routines, learning a new skill, and religious practices are not compulsions. Whether or not behaviors are compulsions or mere habit depends on the context in which the behaviors are performed. For example, arranging and ordering DVDs for eight hours a day would be expected of one who works in a video store, but would seem abnormal in other situations. In other words, habits tend to bring efficiency to one's life, while compulsions tend to disrupt it.

In addition to the anxiety and fear that typically accompanies OCD, sufferers may spend hours performing such compulsions every day. In such situations, it can be hard for the person to fulfill their work, family, or social roles. In some cases, these behaviors can also cause adverse physical symptoms. For example, people who obsessively wash their hands with antibacterial soap and hot water can make their skin red and raw with dermatitis.

People with OCD can use rationalizations to explain their behavior; however, these rationalizations do not apply to the overall behavior but to each instance individually. For example, a person compulsively checking the front door may argue that the time taken and stress caused by one more check of the front door is much less than the time and stress associated with being robbed, and thus checking is the better option. In practice, after that check, the person is still not sure and deems it is still better to perform one more check, and this reasoning can continue as long as necessary.

Without overt compulsions

OCD sometimes manifests without overt compulsions. Nicknamed "Pure-O", OCD without overt compulsions could, by one estimate, characterize as many as 50 percent to 60 percent of OCD cases. Rather than engaging in observable compulsions, the person with this subtype might perform more covert, mental rituals, or might feel driven to avoid the situations in which particular thoughts seem likely to intrude. As a result of this avoidance, people can struggle to fulfill both public and private roles, even if they place great value on these roles and even if they had fulfilled the roles successfully in the past. Moreover, the individual's avoidance can confuse others who do not know its origin or intended purpose, as it did in the case of a man whose wife began to wonder why he would not hold their infant child.

Causes

Scholars generally agree that both psychological and biological factors play a role in causing the disorder, although they differ in their degree of emphasis upon either type of factor.

Psychological

Biological

OCD has been linked to abnormalities with the neurotransmitter serotonin, although it could be either a cause or an effect of these abnormalities. Serotonin is thought to have a role in regulating anxiety. To send chemical messages from one neuron to another, serotonin must bind to the receptor sites located on the neighboring nerve cell. It is hypothesized that the serotonin receptors of OCD sufferers may be relatively understimulated. This suggestion is consistent with the observation that many OCD patients benefit from the use of selective serotonin reuptake inhibitors (SSRIs), a class of antidepressant medications that allow for more serotonin to be readily available to other nerve cells.

A possible genetic mutation may contribute to OCD. A mutation has been found in the human serotonin transporter gene, hSERT, in unrelated families with OCD. Moreover, data from identical twins supports the existence of a "heritable factor for neurotic anxiety". Further, individuals with OCD are more likely to have first-degree family members exhibiting the same disorders than do matched controls. In cases where OCD develops during childhood, there is a much stronger familial link in the disorder than cases in which OCD develops later in adulthood. In general, genetic factors account for 45-65% of OCD symptoms in children diagnosed with the disorder. Environmental factors also play a role in how these anxiety symptoms are expressed; various studies on this topic are in progress and the presence of a genetic link is not yet definitely established.

People with OCD evince increased grey matter volumes in bilateral lenticular nuclei, extending to the caudate nuclei, while decreased grey matter volumes in bilateral dorsal medial frontal/anterior cingulate gyri. These findings contrast with those in people with other anxiety disorders, who evince decreased (rather than increased) grey matter volumes in bilateral lenticular / caudate nuclei, while also decreased grey matter volumes in bilateral dorsal medial frontal/anterior cingulate gyri. Orbitofrontal cortex overactivity is attenuated in patients who have successfully responded to SSRI medication, a result believed to be caused by increased stimulation of serotonin receptors 5-HT2A and 5-HT2C. The striatum, linked to planning and the initiation of appropriate actions, has also been implicated; mice genetically engineered with a striatal abnormality exhibit OCD-like behavior, grooming themselves three times as frequently as ordinary mice. Recent evidence supports the possibility of a heritable predisposition for neurological development favoring OCD.

Rapid onset of OCD in children may be caused by Group A streptococcal infection, a condition hypothesized by its acronym PANDAS.

Neurotransmitters role

Researchers have yet to pinpoint the exact cause of OCD, but brain differences, genetic influences, and environmental factors are being studied. Brain scans of people with OCD have shown that they have different patterns of brain activity than people without OCD and that different functioning of circuitry within a certain part of the brain, the striatum, may cause the disorder. Differences in other parts of the brain and an imbalance of brain chemicals, especially serotonin and dopamine, may also contribute to OCD. Independent studies have consistently found unusual dopamine and serotonin activity in various regions of the brain in individuals with OCD. These can be defined as dopaminergic hyperfunction in the prefrontal cortex and serotonergic hypofunction in the basal ganglia.

Diagnosis

Formal diagnosis may be performed by a psychologist, psychiatrist, clinical social worker, or other licensed mental health professional. To be diagnosed with OCD, a person must have obsessions, compulsions, or both, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM). The Quick Reference to the 2000 edition of the DSM suggests that several features characterize clinically significant obsessions and compulsions. Such obsessions, the DSM says, are recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and that cause marked anxiety or distress. These thoughts, impulses, or images are of a degree or type that lies outside the normal range of worries about conventional problems. A person may attempt to ignore or suppress such obsessions, or to neutralize them with some other thought or action, and will tend to recognize the obsessions as idiosyncratic or irrational.

Compulsions become clinically significant when a person feels driven to perform them in response to an obsession, or according to rules that must be applied rigidly, and when the person consequently feels or causes significant distress. Therefore, while many people who do not suffer from OCD may perform actions often associated with OCD (such as ordering items in a pantry by height), the distinction with clinically significant OCD lies in the fact that the person who suffers from OCD must perform these actions, otherwise they will experience significant psychological distress. These behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these activities are not logically or practically connected to the issue, or they are excessive. In addition, at some point during the course of the disorder, the individual must realize that their obsessions or compulsions are unreasonable or excessive. Moreover, the obsessions or compulsions must be time-consuming (taking up more than one hour per day) or cause impairment in social, occupational, or scholastic functioning. It is helpful to quantify the severity of symptoms and impairment before and during treatment for OCD. In addition to the patient's estimate of the time spent each day harboring obsessive-compulsive thoughts or behaviors, Fenske and Schwenk in their article "Obsessive-Compulsive Disorder:

Diagnosis and Management," argue that more concrete tools should be used to gauge the patient's condition (2009). This may be done with rating scales, such as the most trusted Yale-Brown Obsessive Compulsive Scale (Y-BOCS). With measurements like these, psychiatric consultation can be more appropriately determined because it has been standardized.

Differential diagnosis

OCD is often confused with the separate condition obsessive-compulsive personality disorder(OCPD). OCD is ego dystonic, meaning that the disorder is incompatible with the sufferer's self-concept. Because disorders that are ego dystonic go against a person's self-concept, they tend to cause much distress. OCPD, on the other hand, is ego syntonic--marked by the person's acceptance that the characteristics displayed as a result of this disorder are compatible with his or her self-image.

People with OCD are often aware that their behavior is not rational and are unhappy about their obsessions but nevertheless feel compelled by them. People with OCPD are not aware of anything abnormal; they will readily explain why their actions are rational, and it is usually impossible to convince them otherwise.

People with OCD are ridden with anxiety; by contrast, people with OCPD tend to derive pleasure from their obsessions or compulsions.

Some OCD sufferers exhibit what is known as overvalued ideas. In such cases, the person with OCD will truly be uncertain whether the fears that cause them to perform their compulsions are irrational or not. After some discussion, it is possible to convince the individual that their fears may be unfounded. It may be more difficult to do ERP therapy on such patients because they may be unwilling to cooperate, at least initially. For this reason OCD has often been likened to a disease of pathological doubt, in which the sufferer, though not usually delusional, is often unable to realize fully which dreaded events are reasonably possible and which are not. There are severe cases in which the sufferer has an unshakeable belief in the context of OCD that is difficult to differentiate from psychosis.

OCD is different from behaviors such as gambling addiction and overeating. People with these disorders typically experience at least some pleasure from their activity; OCD sufferers do not actively want to perform their compulsive tasks and experience no pleasure from doing so.

OCD can, like many forms of chronic stress, lead to clinical depression over time. The constant stress of the condition can cause sufferers to develop a deadening of spirit, a numbing frustration, or sense of hopelessness. OCD's effects on day-to-day life, particularly its substantial consumption of time, can produce difficulties with work, finances, and relationships. There is no known cure for OCD, but a number of successful treatment options are available.

Management

According to a team of Duke University-led psychiatrists, behavioral therapy (BT), cognitive behavioral therapy (CBT), and medications should be regarded as first-line treatments for OCD. Psychodynamic psychotherapy may help in managing some aspects of the disorder. The American Psychiatric Association notes a lack of controlled demonstrations that psychoanalysis or dynamic psychotherapy is effective "in dealing with the core symptoms of OCD."

Behavioral therapy

The specific technique used in BT/CBT is called exposure and ritual prevention (also known as "exposure and response prevention") or ERP; this involves gradually learning to tolerate the anxiety associated with not performing the ritual behavior. At first, for example, someone might touch something only very mildly "contaminated" (such as a tissue that has been touched by another tissue that has been touched by the end of a toothpick that has touched a book that came from a "contaminated" location, such as a school.) That is the "exposure". The "ritual prevention" is not washing. Another example might be leaving the house and checking the lock only once (exposure) without going back and checking again (ritual prevention). The person fairly quickly habituates to the anxiety-producing situation and discovers that their anxiety level has dropped considerably; they can then progress to touching something more "contaminated" or not checking the lock at all--again, without performing the ritual behavior of washing or checking.

Exposure ritual/response prevention (ERP) has a strong evidence base. It is generally considered the most effective treatment for OCD.

It has generally been accepted that psychotherapy, in combination with psychotropic medication, is more effective than either option alone. However, more recent studies have shown no difference in outcomes for those treated with the combination of medicine and CBT versus CBT alone.

More recent behavioral work has focused on associative splitting. It is a new technique aimed at reducing obsessive thoughts. The method draws upon the "fan effect" of associative priming: The sprouting of new associations diminishes the strength of existing ones. As OCD patients show marked biases or restrictions in OCD-related semantic networks (e.g., cancer is only associated with "illness" or "death", fire is only associated with "danger" or "destruction"), they are encouraged to imagine neutral or positive associations to OCD-related cognitions (cancer = zodiac sign, animal, crab; fire = fireflies, fireworks, candlelight-dinner). First studies tentatively confirm the feasibility and effectiveness of the approach for a subgroup of patients.

Medication

Medications as treatment include selective serotonin reuptake inhibitors (SSRIs) such as paroxetine, sertraline, fluoxetine, escitalopram and fluvoxamine and the tricyclic antidepressants, in particular clomipramine. SSRIs prevent excess serotonin from being pumped back into the original neuron that released it. Instead, serotonin can then bind to the receptor sites of nearby neurons and send chemical messages or signals that can help regulate the excessive anxiety and obsessive thoughts. In some treatment-resistant cases, a combination of clomipramine and an SSRI has shown to be effective even when neither drug on its own has been efficacious.

Treatment of OCD is an area needing significant improvement in prescribing regimens. Benzodiazepines are sometimes used, although they are generally believed to be ineffective for treating OCD; however, effectiveness was found in one small study. Serotonergic antidepressants typically take longer to show benefit in OCD than with most other disorders they are used to treat. It is common for 2-3 months to elapse before any tangible improvement is noticed. In addition to this, treatment usually requires high dosages. Fluoxetine, for example, is usually prescribed in dosages of 20 mg per day for clinical depression, whereas with OCD the dosage often ranges from 20 mg to 80 mg or higher, if necessary. In most cases antidepressant therapy alone provides only a partial reduction in symptoms, even in cases that are not deemed treatment resistant. Much current research is devoted to the therapeutic potential of the agents that affect the release of the neurotransmitter glutamate or the binding to its receptors. These include riluzole, memantine, gabapentin, N-Acetylcysteine, and lamotrigine. MDMA, which is a powerful and illicit serotonergic drug, has also been anecdotally reported to temporarily alleviate the symptoms of OCD.

The atypical antipsychotics olanzapine, quetiapine, and risperidone have also been found to be useful as adjuncts to an SSRI in treatment-resistant OCD. However, these drugs are often poorly tolerated, and have significant metabolic side effects that limit their use. None of the atypical antipsychotics have demonstrated efficacy as a monotherapy.

Electroconvulsive therapy

Electroconvulsive therapy (ECT) has been found effective in severe and refractory cases.

Psychosurgery

For some, medication, support groups and psychological treatments fail to alleviate obsessive-compulsive symptoms. These patients may choose to undergo psychosurgery as a last resort. In this procedure, a surgical lesion is made in an area of the brain (the cingulate cortex). In one study, 30% of participants benefited significantly from this procedure. Deep-brain stimulation and vagus nerve stimulation are possible surgical options that do not require destruction of brain tissue. In the US, the Food and Drug Administration approved deep-brain stimulation for the treatment of OCD under a humanitarian device exemption requiring that the procedure be performed only in a

hospital with specialist qualifications to do so.

In the US, psychosurgery for OCD is a treatment of last resort and will not be performed until the patient has failed several attempts at medication (at the full dosage) with augmentation, and many months of intensive cognitive-behavioral therapy with exposure and ritual/response prevention. Likewise, in the United Kingdom, psychosurgery cannot be performed unless a course of treatment from a suitably qualified cognitive-behavioral therapist has been carried out.

In children and adolescents

Therapeutic treatment may be effective in reducing ritual behaviors of OCD for children and adolescents. Family involvement, in the form of behavioral observations and reports, is a key component to the success of such treatments. Parental intervention also provides positive reinforcement for a child who exhibits appropriate behaviors as alternatives to compulsive responses. After one or two years of therapy, in which a child learns the nature of his or her obsession and acquires strategies for coping, that child may acquire a larger circle of friends, exhibit less shyness, and become less self-critical.

Although the causes of OCD in younger age groups range from brain abnormalities to psychological preoccupations, life stress such as bullying and traumatic familial deaths may also contribute to childhood cases of OCD, and acknowledging these stressors can play an role in treating the disorder.

The mental technique of "thought stopping" can help reduce or eliminate obsessive thoughts. In this procedure, whenever an individual has an obsessive thought, he or she is encouraged to utter "STOP" in mid-thought to interrupt the obsession. A variant of the process avoids making the word "STOP" a stimulus to the obsessive thoughts: in the presence of an obsessive thought, a child counts loudly backward from ten, and then evokes a pleasant scene.

Experimental

The naturally occurring sugar inositol has been suggested as a treatment for OCD, as it appears to modulate the actions of serotonin and reverse desensitisation of neurotransmitter receptors.

Nutrition deficiencies may also contribute to OCD and other mental disorders. Vitamin and mineral supplements may aid in such disorders and provide nutrients necessary for proper mental functioning.

μ-Opioids, such as hydrocodone and tramadol, may rapidly ameliorate OCD symptoms. Tramadol is an atypical opioid that appears to provide the anti-OCD effects of an opiate and inhibit the re-uptake of serotonin (in addition to norepinephrine) Oral morphine, administered once weekly, has

been shown to reduce OCD symptoms in some treatment-resistant patients. The mechanism of therapeutic action is unknown. Administration of opiate treatment may be contraindicated in individuals concurrently taking CYP2D6 inhibitors such as fluoxetine and paroxetine.

Psychedelics such as LSD, peyote, and tryptamine alkaloid psilocybin have been proposed as treatment due to their observed effects on OCD symptoms. It has been hypothesised that hallucinogens may stimulate 5-HT2A receptors and, less significantly, 5-HT2C receptors, causing an inhibitory effect on the orbitofrontal cortex, an area of the brain strongly associated with hyperactivity and OCD.

Regular nicotine treatment may ameliorate symptoms of OCD, although the pharmacodynamical mechanism by which this is achieved is not yet known, and more detailed studies are needed to fully confirm this hypothesis.

Since choline's anti-dopaminergic effects often worsen OCD symptoms, anticholinergics are sometimes used as a supplementary treatment for OCD symptoms.

St John's Wort was previously believed to be of benefit due to its (non-selective) serotonin re-uptake inhibiting qualities, but a double-blind study using a flexible-dose schedule (600-1800 mg/day) found no difference between St John's Wort and a placebo.

Epidemiology

OCD does not have a higher affinity for a specific gender. In 80% of cases, symptoms present before the age of 18. Studies have placed the prevalence of the disorder at between one and three percent, although the prevalence of clinically recognized OCD is much lower, suggesting that many individuals with the disorder may not be diagnosed. The fact that many individuals do not seek treatment may be due in part to stigma associated with OCD.

In a 1980 study of adults from several U.S. cities, the lifetime prevalence rate of OCD for both sexes was recorded at 2.5 percent. Education also appears to be a factor. The lifetime prevalence of OCD is lower for those who have graduated from high school than for those who have not (1.9 percent versus 3.4 percent). However, in the case of college education, lifetime prevalence is higher for those who graduate with a degree (3.1 percent) than it is for those who have only some college background (2.4 percent). As far as age is concerned, the onset of OCD usually ranges from the late teenage years until the mid-20s in both sexes, but the age of onset tends to be slightly younger in males than in females.

A study suggests that OCD symptoms in Japanese patients are similar to those found in Western countries, suggesting that this disorder transcends culture and geography. The study, published in 2008, appears to contradict previous theories, said the study's lead author, Hisato Matsunaga.

Having "hypothesized that symptom structure might be substantially influenced by the sociocultural differences", Hisato said that he was surprised by the results.

It has been proposed that sufferers are generally of above-average intelligence, as the very nature of the disorder necessitates complicated thinking patterns.

Comorbidity

People with OCD may be diagnosed with other conditions, such as major depressive disorder, generalized anxiety disorder, anorexia nervosa, social anxiety disorder, bulimia nervosa, Tourette syndrome, Asperger syndrome, compulsive skin picking, body dysmorphic disorder, trichotillomania, and (as already mentioned) obsessive-compulsive personality disorder. There is some research demonstrating a link between drug addiction and OCD as well. Many who suffer from OCD also suffer from panic attacks. There is a higher risk of drug addiction among those with any anxiety disorder (possibly as a way of coping with the heightened levels of anxiety), but drug addiction among OCD patients may serve as a type of compulsive behavior and not just as a coping mechanism. Depression is also extremely prevalent among sufferers of OCD. One explanation for the high depression rate among OCD populations was posited by Mineka, Watson, and Clark (1998), who explained that people with OCD (or any other anxiety disorder) may feel depressed because of an "out of control" type of feeling. In further consideration of OCD comorbidities, the research of Fenske and Schwenk reports that studies have shown that depression among those with OCD is particularly alarming because their risk of suicide is high; more than 50 percent of patients experience suicidal tendencies, and 15 percent have attempted suicide. Individuals with OCD have also been found to be affected by delayed sleep phase syndrome at a substantially higher rate than the general public.

Prognosis

Psychological interventions such as behavioral and cognitive-behavioral therapy as well as pharmacological treatment can lead to substantial reduction of OCD symptoms for the average patient. However, OCD symptoms persist at moderate levels even following adequate treatment course and a completely symptom-free period is uncommon.

Cognitive performance

OCD is associated with higher IQ.

A 2009 study that conducted "a battery of neuropsychological tasks to assess nine cognitive domains with a special focus on executive functions concluded that "few neuropsychological differences emerged between the OCD and healthy participants when concomitant factors were

controlled."

History

From the 14th to the 16th century in Europe, it was believed that people who experienced blasphemous, sexual, or other obsessive thoughts were possessed by the Devil. Based on this reasoning, treatment involved banishing the "evil" from the "possessed" person through exorcism. In the early 1910s, Sigmund Freud attributed obsessive-compulsive behavior to unconscious conflicts that manifest as symptoms. Freud describes the clinical history of a typical case of "touching phobia" as starting in early childhood, when the person has a strong desire to touch an item. In response, the person develops an "external prohibition" against this type of touching. However, this "prohibition does not succeed in abolishing" the desire to touch; all it can do is repress the desire and "force it into the unconscious".

Society and culture

British poet, essayist, and lexicographer Samuel Johnson is an example of a historical figure with a retrospective diagnosis of OCD. He had elaborate rituals for crossing the thresholds of doorways, and repeatedly walked up and down staircases counting the steps.
American aviator and filmmaker Howard Hughes is known to have suffered from OCD. Friends of Hughes have mentioned his obsession with minor flaws in clothing and he is reported to have had a great fear of germs, common among OCD patients.
English footballer David Beckham has been outspoken regarding his struggle with OCD. He has told media that he has to count all of his clothes, and his magazines have to lie in a straight line. He has expressed a desire to get help for his problems.
American game show host Marc Summers has written a book about how OCD has affected his life. The book is titled Everything in Its Place: My Trials and Triumphs with Obsessive Compulsive Disorder.
Movies and television often portray idealized representations of disorders such as OCD. These depictions may lead to increased public awareness, understanding, and sympathy for such disorders.
Melvin Udall played by Jack Nicholson in As Good As It Gets repeatedly lock and unlock his door, wouldn't step on any cracks, and brought his own plastic cutlery to a restaurant. There were other indications that he had OCD.