UNIT 2 GENERALISED ANXIETY DISORDER AND OBSESSIVE COMPULSIVE DISORDER

Structure

2.0 INTRODUCTION

Would I be able to go to office in time? Is my dress suitable for my job? Am I capable of what I am supposed to do? Will the boss be angry over me? Would my children come back from school safely? What if my wife forgets to put off the gas cylinder and have a terrible accident? Is it possible that I am robbed of my belongings on my way back home?

You must have come across some persons around you who are known as nervous and shaky in general. They seem to be high strung, and anxious over every single step in life.

In some of such persons the anxiety becomes so severe that their everyday functioning may be impaired. You may also notice that in some persons there is an unnatural concern for doing certain things in a right way. Am I clean enough? Did I lock the door properly? Could it so happen that I might actually choke my baby girl to death while playing with her? Such doubts and over concern with unnecessary and at times bizarre issues constitute another category of anxiety disorders.

In this unit you would learn about two such disorders: Generalised Anxiety Disorder and Obsessive Compulsive Disorder. Both these disorders are characterised by prolonged and continuous anxiety. In the earlier unit you have learnt about panic attack and phobia, which are episodic and may be in response to specific conditions. The two disorders that you would be learning in this section are characterised by relatively persistent anxiety and reduce the overall functionality of the individual. You would also read case studies exemplifying the typical symptoms. The names of all case studies used here are fictitious and all important identifying information has been changed to maintain anonymity of the persons.

2.1 OBJECTIVES

After you complete this unit, you will be able to:

- Define generalised anxiety disorders;
- Describe the symptoms of generalised anxiety disorder;
- Discuss the aetiology of generalised anxiety disorder;
- Explain the treatment of generalised anxiety disorder;
- Describe the symptoms of obsessive compulsive disorder;
- Analyse the aetiology of obsessive compulsive disorder; and
- Elucidate the treatment of obsessive compulsive disorder.

2.2 GENERALISED ANXIETY DISORDER (GAD): SYMPTOMS AND CLINICAL FEATURES

You may very well guess from the nomenclature itself that Generalised Anxiety Disorder (popularly known as GAD) is an over generalised anxiety over many things. GAD is characterised by excessive and irrational anxiety over minor things. The DSM IV –TR characterises GAD in terms of persistent excessive anxiety and worries which the person finds difficult to control. There are 6 specific symptoms among which at least 3 must be present to be diagnosed as GAD. These are:

- Restlessness or feeling keyed up
- Being easily fatigued
- Difficulty in concentrating
- Irritability
- Muscle tension
- Sleep disturbance

GAD is also known as free floating anxiety in psychodynamic terms, because the anxiety does not seem to be bound to one or few specific issues. The person typically is terrified of different possible mishaps. If you convince the person of the irrationality of one issue, or if, in the course of natural affairs, one issue is resolved, the person takes up a second and a third issue and focuses on them. Concentration to anything for a given period of time becomes extremely difficult, as some or other point of anxiety always comes up. Somatic complaints like sweating, flushing, palpitation, upset stomach, lump in throat, frequent urination, rapid breathing, twitches and tics are common. The person becomes fidgety, irritable and easily fatigued. Often vivid imageries of the disaster accompany the restlessness. Impatience, anger outbursts and insomnia are common.

Many persons with GAD lead their life more or less normally without consulting any doctor. They have some functional impairment and difficulties within the family; but the problems may be somewhat manageable with some support from the close ones. For about one third cases, spontaneous recovery takes place at some point in life. For others the problem is severe enough to seek medical consultation, although the chief complaint is often presented as somatic problems or insomnia.

2.2.1 A Case Study of Generalised Anxiety Disorder

Fatema, now a housewife of 35 years of age, had always been nervous since her childhood. During her school days, she had been anxious for her studies and examinations. She was also extremely upset if any of her friends talked ill about her or the teachers scolded her. At home she became greatly worried if her father came home later than usual. She apprehended some accident. She was admitted to college, but did not finish her graduation. She married at the age of 22. Her husband had a small business in the town. Fatema was from the very beginning apprehensive about the possible failure of her husband's business and worried over any temporary loss that occurred. Initially her husband was glad to see her worried, as he interpreted it as her attachment to him. Gradually he became irritated at the constant worry and negative predictions she had. He tried to convince her that every business has its own ups and downs, and there is nothing to be worried about. The effort was of little effect. At the age of 26 Fatema gave birth to a girl, and after four years to a boy. During pregnancy she was extremely fearful that the pregnancy would go wrong and some damage might occur to her unborn child. Fatema's family consulted some 'pirbaba' (local saint) who gave her some pious water and assured her that everything would be alright, and she was consoled a bit. Now her daughter being in puberty, Fatema is extremely worried that some harm might befall her, and remains anxious till the girl comes back home from school. Fatema fears that she might be assaulted on her way back home. Fatema's son is also growing up, and Fatema is worried that he might hurt himself during play. She reports bad dreams and apprehends that these might come true. She restricts her son's movement causing lots of argument and dissatisfaction within the family. However, she becomes so anxious and starts crying instead of rationally justifying her stand that her husband and children ultimately compromise with her demands. Fatema remained happy and relaxed for a negligible period of her life, always apprehending that some danger might befall her and her loved ones. She is a frequent visitor to the 'pirbaba', and remains temporarily calm only after he had blessed her for a safe life.

2.3 PREVALENCE OF GENERALISED ANXIETY DISORDER

The prevalence rate of GAD is quite high, estimated to be about about 3% to 5% of the general population. It usually begins in the teens and is more common in women. It often has other anxiety disorders and mood disorders as co-morbid condition.

2.4 AETIOLOGY OF GENERALISED ANXIETY DISORDER

The aetilogy of GAD may be classified into two groups i.e.

i) biological and

ii) psychological factors.

2.4.1 Biological Factors

1) **Genetic factors:** Research indicates a moderate role of genetic factors. The research in this area has been confounded by the different expressions of anxiety. There is also some indication that GAD and major depressive disorder may share a common underlying genetic predisposition.

2) **Brain and biochemical abnormalities:** The neurotransmitter called Gamma aminobutyric acid (GABA) has been implicated in GAD. Deficiency in GABA seems to predispose one toward anxiety. Furthermore, since the cortisol level goes up under stress, the corticotrophine releasing hormone (CRH) has also been considered as playing a significant role in GAD. There are some indications that serotonin and norepinephrine may also have some role in producing GAD.

2.4.2 Psychological Factors

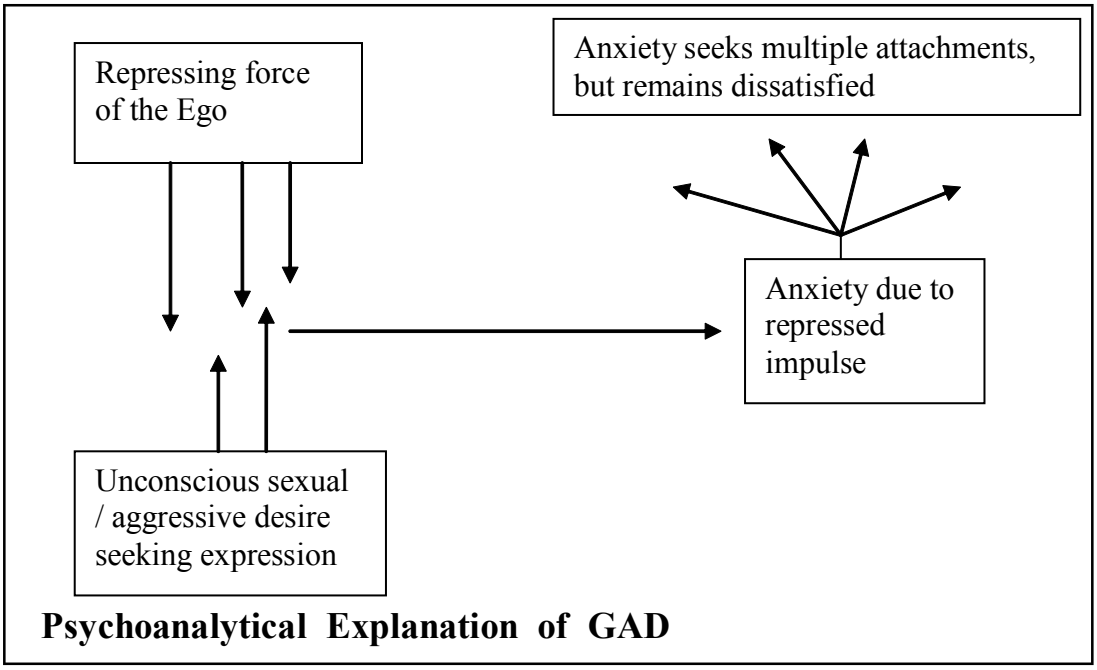
1) **Psychoanalytical approach:** The psychoanalytical approach traces the free floating anxiety in GAD to the unconscious conflict between the ego and id impulses, usually sexual and aggressive in nature. It states that we often have socially unaccepted desires, and these desires do not come out in the consciousness because of the repression of the ego. These desires are continuously seeking expression, but are repeatedly thwarted and hence the anxiety. The source of the anxiety is in the unconscious, and therefore, not known. It seeks to be attached to one object or another, with little success.

2) **Cognitive behavioural approach:** In the cognitive behavioural approach, the role of worry and sense of mastery has been emphasised. It has been noted that actual occurrence of uncontrollable negative events in life has a role to play in GAD. If you go through the life story of a person suffering from GAD, you may find that the events are usually not as traumatic as in the cases of Post Traumatic Stress Disorder. But there is often a series of small events that generate a perception of lack of control on things around. You may also note that the person's early environment was so construed that she was never allowed to feel safe and relax. A relative lack of safety signals characterises the person with GAD.

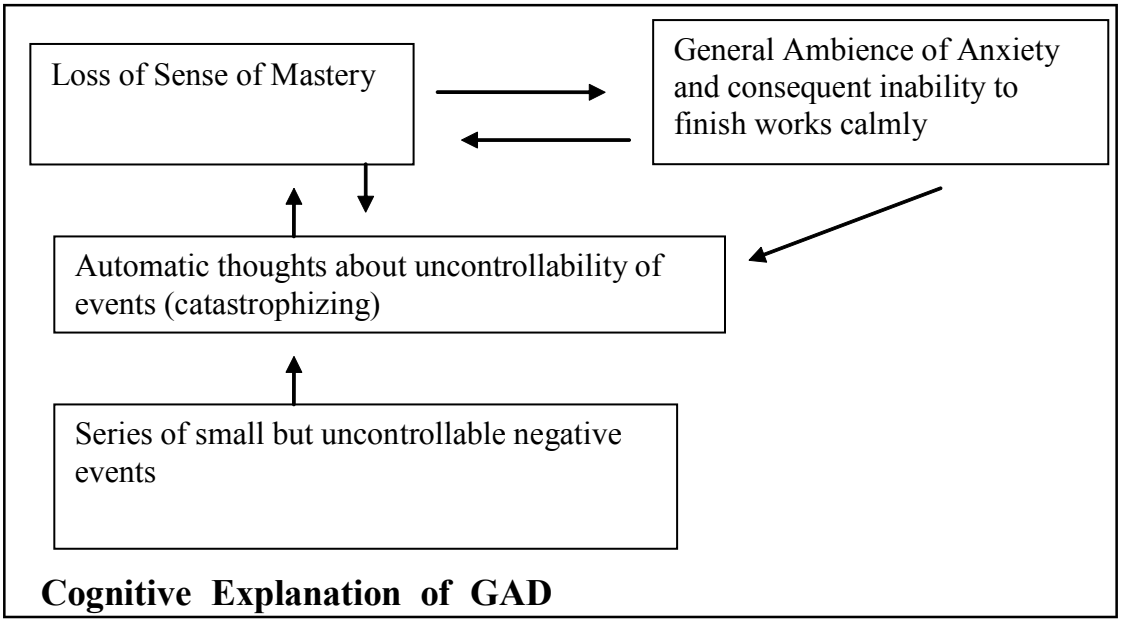
You need to remember in this context that worry and anxiety has some positive functions. Anxiety helps you to avoid catastrophe, avoid deeper and disturbing emotional thoughts, coping and preparing for negative events and motivating to do certain things. On the other hand worry impairs the ability to stay happy, reduces sense of well being and makes you vulnerable to uncontrolled or intrusive thoughts. It has also been noted that if you try to stop being anxious, it often has a rebound effect to encourage more intrusive thoughts. Thus a vicious cycle may be formed.

Cognitive theorists have also noted that the information processing of the person with GAD is biased. She detects the threatening events more quickly in comparison to the non-threatening ones. Also, the imagery associated with negative events seems to linger longer and prominently in them.

Diagram explaining psychoanalytical and cognitive explanation of anxiety disorder



Cognitive Explanation of Generalised Anxiety Disorder



2.5 TREATMENT OF GENERALISED ANXIETY DISORDER

So far the biochemical treatment is concerned; different drugs from the Benzodiazepine category have been used extensively. While this drug relieves anxiety immediately, it may be habit forming. Another drug called Buspirone is also being prescribed for GAD; however it takes a few weeks to work. Different antidepressants have also been used.

To deal with the psychological factors, you may use a combination of cognitive and behavioural techniques. However, GAD remains one of the relatively difficult anxiety problems to treat, because the direct effort to stop negative thoughts usually results in a renewed invasion of such thoughts. Muscular relaxation may be combined with cognitive restructuring. You may also point out the biased nature of information processing and train your client to avoid catastrophizing tendencies.

Self Assessment Questions

1) How many of the six symptoms must be there for GAD to be diagnosed?

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2) What is free floating anxiety?

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3) What is the nature of cognitive bias in GAD?

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4) Write *True* (T) or *False* (F) beside the statement

   a) In a person with GAD, there are often histories of series of small negative events ( ).

   b) Buspirone is a very quick acting drug ( ).

2.6 OBSESSIVE COMPULSIVE DISORDER (OCD): SYMPTOMS AND CLINICAL FEATURES

You must be acquainted with the word obsessive and compulsive – these two terms have actually been part of everyday language. But you must learn at the very outset to distinguish the layman's usage of obsession and compulsion from their technical usage. Obsession in everyday usage means being engrossed in specific thoughts – you speak of being obsessed with your looks, your daughter's studies, your girlfriend's whereabouts while she is away from you. You also talk of being obsessed with a particular art form, of guns and rifles, of cars, of stamps from different countries. Compulsion means you are forced or compelled to do something. In ordinary language we may use it to be forced from outside (compelled by my parents) or from inside (compelled by my conscience). But you must remember that these are not technically correct use of the terms obsession and compulsion. So long you are happy and in control of these thoughts, and so long these are not intrusive despite your earnest effort to ward them away they are simply fancy words and not components of a disorder.

Technically, obsession means intrusive thoughts, images and impulses often of a negative or unacceptable kind, despite one's desire to get rid of it. Compulsion means being compelled from within to perform certain ritualistic acts, because otherwise you are afraid of some danger befalling you. According to DSM IV- TR, obsessions are recurrent and persistent thoughts, impulses or images that are experienced as intrusive and generate considerable anxiety. These thoughts do not concern real life problems at the moment, and are often irrelevant to present reality. The person has insight and tries to remove these thoughts, but often cannot succeed.

If you look into the content of the obsessive thoughts, you may find unusual fear of contamination, fear of harming oneself or one's own loved ones, religious themes, themes of sexuality specially the unacceptable forms, wishing ill for others (for example

wishing one's mother dead), doubt about whether one has accomplished things properly. The person does not want to think of these, and when particularly aggressive and sexual thoughts predominate, considers herself 'bad'. Yet the thoughts continue to haunt her.

Compulsions are repetitive overt behaviours like washing or checking or mental acts like counting or praying in response to an obsessive thought. Compulsions are to be done following rigid rules to prevent or reduce the impact of some dreaded thing or action. After a compulsion is performed the person temporarily feels relieved, but again succumbs to the same cycle.

There are a few primary kinds of compulsive acts. These are cleaning (for example, repeated washing), checking (for example, repeatedly coming back to home to check if the door has been locked properly), counting (for example, counting the number of steps one takes before getting on the bed), repeating (for example, coming back to the first word of the line as one is not sure if she has read it properly), hoarding (for example, collecting things and not being able to dispose of these things), and ordering (for example, arranging books on the table in a particular order each time one leaves the table).

While in most cases, you will find obsessions and compulsion as coexistent, there may be cases where only obsession or compulsion predominates. The obsessions and compulsions take plenty of time from one's daily routine and slow down the entire life process. For some, rituals take the whole day resulting in the sufferer's inability to anything else at all. Sometimes it results in health hazard; you may rub and clean your skin so much and with such material (like raw dettol) that there are wounds on your body. Also for most people there are multiple obsessions and compulsions.

The anxiety accompanying OCD is two fold. In the first place, the obsessive thoughts are unpleasant and anxiety provoking. Compulsions reduce them to some extent, but the very insight that one is compelled to do such useless things causes lack of confidence and severe distress. In fact World Health Organization found obsessive compulsive disorder to be the world's leading cause of disability. It has also been associated with unemployment, marital problem and separation, and impaired social functioning.

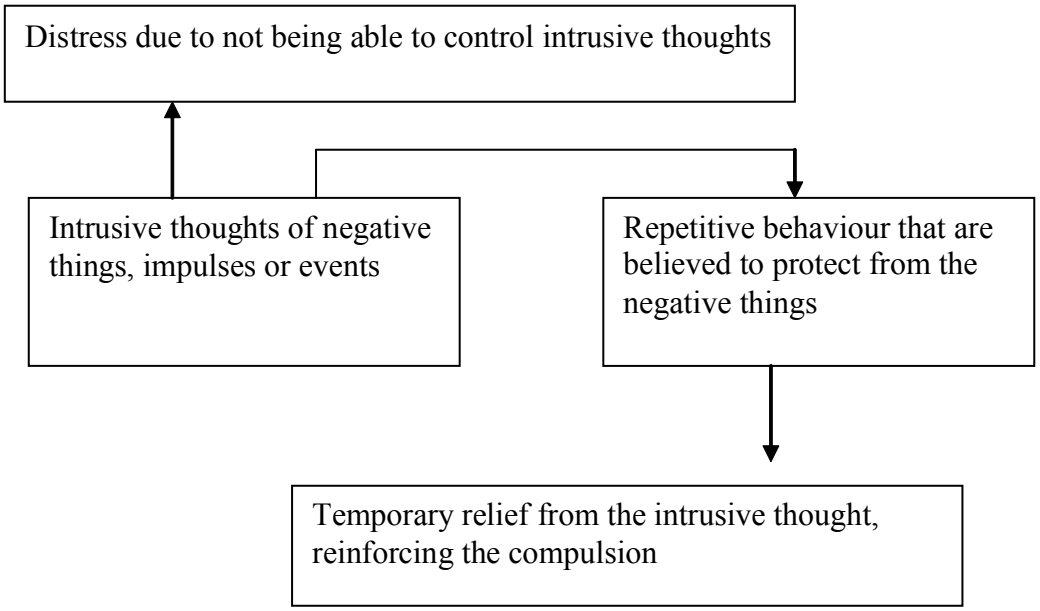

Fig.: Relation between Obsession and Compulsion

2.6.1 A Case Study of Obsessive Compulsive Disorder

Raj is a 26 years old man of considerable intelligence. He comes from an upper middle class family. He is presently employed at a private firm. His difficulty started some ten years back at the late teens, when he was walking on the pavement. He accidentally stepped on something which he did not bother about at the moment. But back home, it came to his mind that it might have been a used condom. He felt very unclean and washed himself thoroughly. He knew that he might have been wrong in his interpretation, but the thought continued to haunt him. Gradually he became afraid of stepping over anything dirty on the street, be it condom, faeces, or sputum. What particularly disturbs him is the vivid imagery of the person who has soiled the street. Now he takes pains to look at the road very carefully before stepping and if ever he sees anything he avoids that particular street for a few days if possible. It so happens that the city he lives in is not particularly clean and often there are actually dirty things on the street. If he sees anything like this he has to wash himself following certain rituals after he reaches home.

Intrusive imagery of filthy sticky things haunts him till he is back home and washes himself. He first washes his face ten times, then his arms, chest, back and legs for specific number of times. He has to take care of his feet particularly, being forced to wash them twenty five times each. The washing ritual has to be completed irrespective of heat and cold, and irrespective of his health, even if he has fever.

He also has to wash the surface of the soap he uses, as that too might be contaminated. Since he needs about three hours to wash himself, he takes dinner quite late and has difficulty waking up in the morning and coping with the stress of his job. As he has to avoid certain streets on certain days, he is often late at his office.

His concentration is failing since he is always thinking if there are filthy things stuck in his feet. With repeated warnings and humiliations from his boss he is thinking of leaving this job and look for another with lower salary but less demanding conditions.

2.7 PREVALENCE OF OBSESSIVE COMPULSIVE DISORDER

OCD seems to be present in about 2% to 3% of general population. Its onset may be in adolescence or early adulthood, and has a gradual onset. Childhood onset is also possible. Usually the cases with childhood onset tend to be very severe. If it becomes severe, it usually turns chronic. The risk is equal for both sexes. However, the content of obsession and compulsion may vary across age and sex. OCD may occur concurrently with depression, phobia, panic disorder, GAD and also body dysmorphic disorder.

2.8 AETIOLOGY OF OBSESSIVE COMPULSIVE DISORDER

Biological and psychological factors play significant role in the genesis of OCD. The obsessive and compulsive symptoms are often similar across cultures and across social class, though the specific content may vary a bit.

2.8.1 Biological Factors

Biological factors include genetic factors and brain abnormality.

1) **Genetic factors:** Moderate genetic inheritance has been observed in case of OCD. There is a moderate concordance rate for monozygotic twins. One

strong evidence in favour of genetic basis is the connection of OCD and Tourette's syndrome. Tourette's syndrome is a childhood disorder of chronic tics and has a strong genetic basis. It has been found that a large number of first degree relatives of children with Tourett's syndrome has OCD. OCD has also been found to be associated with childhood autism, again a disease with genetic causes. Evolutionary perspective further suggests that as in case of phobia, there is a preparedness factor in OCD. For example, obsession about contamination is much more common than obsession about pencils.

2) **Brain and biochemical abnormalities:** Some parts of the brain, particularly caudate nucleus, orbital frontal cortex and the cingulated cortex have been found to show excessive metabolic activity in OCD patients. Diseases like encephalitis and brain tumours have also been found to ritualistic behaviour, thus implicating certain parts of the brain abnormality for OCD. There has also been some evidence that increased activity of the neurotransmitter called serotonin and enhanced sensitivity of the stated brains structures to serotonin are also associated with OCD.

2.8.2 Psychological Factors

1) **Psychoanalytical theory:** Psychoanalytical approach attributes obsession to a fixation to the anal phase of life. Too strict toilet training predisposes the child toward over conscientiousness. The unconscious impulse to soil and play with filth, natural in a child of anal phase is so strongly prohibited that the child takes recourse to defenses like reaction formation by being overly clean and undoing by rituals. Paradoxically, obsession also provides a way of vicarious satisfaction of the prohibited impulse. If you are thinking for the whole day about how to stay away from dirt, you are, in a way, thinking of dirt only.

2) **Learning theories:** Neutral stimuli may be associated through classical conditioning with frightening ideas and become capable of eliciting intense anxiety. For example, Raj may have acquired the fear of dirty things on the street because he was thinking of something negative while walking on the street, and the object on the street became associated with it. Since the connection was not logical, Raj could not explain it. Learning theory further states that since compulsions reduce anxiety to a large extent, they become reinforced and continue in a cyclic manner. One implication of this theory is that if you expose the person to the object that provokes obsession, and then prevent the ritualistic compulsive behaviour, the reinforcement of the compulsion would be withdrawn. Gradually, the person would be able to understand that anxiety reduction is possible without compulsive acts.

3) **Cognitive theories:** Cognitive approaches suggest that there are negative automatic thoughts behind obsession. Often the persons with OCD are apparently excessively responsible and perfectionistic. This may have been the result of childhood training. However, if they think of something obnoxious, which we all do occasionally, they cannot separate it from acting it out in reality. This is called thought-action fusion. This fusion makes it easier for catastrophic thinking to take place. Of course, if you think that some harm may come to your friend, and you confuse it with your actually harming the friend, the results would be catastrophic.

Cognitive bias is of course apparent in obsession. The attention of persons with OCD goes easily to the concern of obsession in comparison to any other neutral

stimulus. They seem to have problem in information processing as well. Their memory seems to be selectively distorted as they cannot remember if they have done a thing properly or not, resulting in repetitive behaviour. They also have difficulty in suppressing irrelevant information.

2.9 TREATMENT OF OBSESSIVE COMPULSIVE DISORDER

Psychoanalytically oriented therapy or insight therapies are of little use for OCD patients. Behaviour therapy and medication are most popularly used modes of therapy. Behaviour therapy seems to have a higher percentage of completed treatment, compared to medication.

The specific behaviour therapy that works best for the OCD is the Exposure and Response Prevention (E&RP). In E&RP you need to encourage the person to expose themselves to their obsessions. Then they must prevent themselves from the ritualistic acting out of the compulsions to get rid of the anxiety generated by the obsession. As they are repeatedly faced with their fear and can reduce their anxiety without compulsion they get 'habituated' to the new experience.

For example if you want to treat a lady who is bothered by the intrusive thought of possible harm of her husband, and then counts up to seven to protect him from the harm, you must first allow her to be subject to the thought. This is exposure. Then you have to prevent her from counting. You may distract her by discussing the possibility of the harm and after some talking she may feel the fear of harm a bit less. Then you reinforce this behaviour and ask her to practice it. You can give her homework as well so that she may record the number of successful response prevention at home. Gradually she may be convinced that obsessive anxiety may go away even without the counting.

Among the medicines used most frequently with OCD cases are Clomipramine and Fluoxetine.

It has been observed that the improvement rate is moderate. Particularly when the medicine is discontinued there is chance of relapse unless behaviour therapy has been continued along with medicine.

You need to remember that OCD is one of the most difficult to cure diseases. However, even if the entire range of obsessive thoughts and compulsive acts cannot be cured, it is possible to reduce its severity considerably so that one can lead a considerably successful life.

Self Assessment Questions

1) Define obsession and compulsion.

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2) How prevalent is OCD in the population?

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3) What is thought-action fusion?

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4) Write *True* (T) or *False* (F) beside the statement

a) There can be cases with obsessions only with no symptom of compulsion ( ).

b) In terms of learning theory compulsions are maintained by reinforcement, since they reduce anxiety ( ).

c) E&RP stands for Exposure and Repeated Practice ( ).

2.10 LET US SUM UP

In this unit we have focussed specifically on two Anxiety disorders which have relatively long term and pervasive impact on functionality. We have learnt the symptoms and clinical features of the Generalised Anxiety Disorder and Obsessive Compulsive Disorder. The prevalence of these disorders in the general population and time of onset have also been discussed. We have learnt about their aetiologies in terms of biological and psychological factors. We have also been acquainted with some of the biological and psychological treatment approaches to these disorders. For both of these disorders medicine has only moderate success. Psychoanalytically oriented treatment also has little impact. Cognitive behavioural approach seems to be the best option.

2.11 UNIT END QUESTIONS

1) Discuss the symptoms and clinical features of Generalised Anxiety Disorder with case examples.

2) State the prevalence rate of Generalised Anxiety Disorder.

3) Discuss the aetiological factors of Generalised Anxiety Disorder.

4) Discuss the treatment options of Generalised Anxiety Disorder.

5) Discuss the symptoms and clinical features of Obsessive Compulsive Disorder with case examples.

6) State the prevalence rate of Obsessive Compulsive Disorder.

7) Discuss the aetiological factors of Obsessive Compulsive Disorder.

8) Discuss the treatment options of Obsessive Compulsive Disorder.

2.12 GLOSSARY

Generalised Anxiety Disorder : Persistent excessive anxiety and worry on a number of things, which the person finds difficult to control.

Obsessive Compulsive Disorder : A psychiatric disorder characterised by intrusive thoughts or images of some negative event, impulse or thing (obsession) and ritualistic acts to undo or prevent these obsessive thoughts (compulsion).

Tourette's syndrome : A disorder characterised by muscle and vocal tics.

Thought – action fusion : Inability to separate thinking of something from acting it out. This is typical of obsessive compulsive disorder, where one seems to be disturbed by the mental thoughts and impulses, although these are not occurring in reality.

Exposure and Response Prevention : A behavioural treatment of Obsessive Compulsive Disorder where the person is exposed to the feared thought and the compulsive act is prevented. Gradually the person becomes habituated to dealing with the obsessive anxiety without resorting to the compulsion.

2.13 SUGGESTED READINGS

Kaplan, H. I. & Sadock, B. J. *Synopsis of Psychiatry.* Philadelphia: Lippincott Williams.

Semple, D., Smyth, R., Burns, J., Darjee, R. & McIntosh, A. (2005) *Oxford Handbook of Psychiatry*. London: OUP.