

Characteristics

Definitions and types

People can have **obsessions, compulsions** or both, with **obsessive–compulsive disorder (OCD)** being one of the most common anxiety disorders. Some estimate 69% of those diagnosed have obsessions *and* compulsions (with 25% just obsessions and 6% just compulsions). Generally, there is some trigger event, followed by obsessive thoughts, which cause discomfort if not resolved (e.g. something might not have been done, or something might happen or cause a problem). There might then be the ritual of checking (e.g. to confirm something has been done) or washing (e.g. to remove a contamination). The compulsion involves repeating the action continually.

Examples of obsessions include:

- fearing contamination from dirt, bacteria, etc. when touching surfaces
- imagining a fire breaking out in every building entered.

Compulsions include:

- washing hands many times until they are thoroughly clean
- checking fire exits or exit route in every building entered
- doubting and so reading an email many times before sending it to ensure it is correct
- touching repeatedly, such as a door, to see if it is closed.

Hoarding has the following features:

- accumulation of things that have little or no value
- difficulty in discarding or parting with things
- indecision about what to keep or where to put things
- severe anxiety when attempting to discard things
- difficulty categorising or organising things.

The ‘things’ people hoard include newspapers, magazines, paper and plastic bags, cardboard boxes, photographs, household supplies, and often animals. They hoard them for the following reasons:

- Prevention of harm: people fear harm if things are thrown away.
- Deprivation hoarding: people feel that they might need the thing at some point in the future.
- Emotional: a belief that the thing has some emotional significance.

Body dysmorphic disorder (BDD) has three main features:

- A preoccupation with some imagined defect in appearance in a normal appearing person. If a slight physical anomaly is present, the person’s concern is markedly excessive.
- The preoccupation causes clinically significant distress or impairment in social, occupational or other important areas of functioning.
- The preoccupation is not better accounted for by another mental disorder.

The most commonly disliked body areas are: skin (73%), hair (56%) and nose (37%) but can it also be eyes, feet, or any other body part. Typical BDD behaviours include:

- camouflaging (91%) with body position or posture, with clothing, make-up, etc.
- comparing the body part with others (88%)
- checking appearance in mirrors (i.e. mirror gazing) (87%)

72% of people with BDD seek cosmetic/plastic surgery but this is of little use because BDD is a psychological disorder and any physical change will not ‘cure’ the person.

Both hoarding and BDD are best treated with cognitive behaviour therapy.

An **obsession** is a recurring and persistent thought that interferes with normal behaviour.

A **compulsion** is a recurring action a person is forced to enact.

Obsessive–compulsive disorder is where irresistible thoughts and actions must be acted on.

Expert tip

Hoarding is a pattern of behaviour that is characterised by excessive acquisition and an inability or unwillingness to discard large quantities of objects that cover the living areas of the home and cause significant distress or impairment.

Expert tip

Body dysmorphic disorder (BDD) is a condition marked by an excessive pre-occupation with an imaginary or minor defect in a facial feature or localised part of the body.

Examples and case studies

A **case study of OCD** is that of 'Charles' by **Rapoport** (1989). When aged 12, Charles started to wash compulsively. He followed the same ritual each day in the shower, which would take him up to 3 hours. Getting dressed would take another 2 hours. Charles was treated by Rapoport who prescribed the drug Anafranil and linked this with a behavioural management programme, such as washing in the evening. For a while the symptoms disappeared. Over time Charles went on to cope with his disorder.

An **example of a BDD** sufferer is Kayla who never goes out and spends hours looking in a mirror: 'I hate my face, my eyes, my nose, my jaw, my mouth'. She is clinically significantly distressed about her appearance. She has had nine operations on her nose, but because she is delusional (a false fixed belief that cannot be changed) she is considering further surgery.

Measures

The **Maudsley obsessive-compulsive inventory** (MOCI) is a psychometric test originally designed by Hodgson and Rachman (1977) to assess OCD. It is a self-report questionnaire using a forced-choice 'yes' or 'no' format. It has 30 questions/items with four sub-scales:

- **Checking** (9 items), for example 'I frequently have to check things (gas or water taps, doors etc.) several times'.
- **Cleaning/washing** (11 items), for example 'I am not unduly concerned about germs and diseases' (reverse scored).
- **Slowness** (7 items), for example 'I am often late because I cannot seem to get through everything on time'.
- **Doubting** (7 items), for example 'I have a very strict conscience'.

A person can have a total score between 0 (no symptoms) and 30 (maximum presence of symptoms). This determines the nature, extent and severity of the OCD.

The **Yale-Brown obsessive-compulsive scale** (Y-BOCS) is designed to rate the severity and type of symptoms in patients with OCD. It is intended to be used as a semi-structured interview, which means in addition to the standard questions, the interviewer is free to ask additional questions for purposes of clarification and the patient can give more information at any time during the interview.

There are questions about obsessions and about compulsions such as:

How much of your time is occupied by obsessive thoughts?

- 0 None
- 1 Mild, less than 1 hr/day or occasional intrusion
- 2 Moderate, 1 to 3 hrs/day or frequent intrusion
- 3 Severe, greater than 3 and up to 8 hrs/day or very frequent intrusion
- 4 Extreme, greater than 8 hrs/day or near constant intrusion

How much time do you spend performing compulsive behaviours (or how frequently are they performed)?

Overt Covert

- | | | |
|---|---|--|
| 0 | 0 | None |
| 1 | 1 | Less than 1 hr/day or occasional performance of compulsive behaviour |
| 2 | 2 | Between 1 and 3 hrs/day, or frequent |
| 3 | 3 | Between 3 and 8 hrs/day, or very frequent |
| 4 | 4 | More than 8 hrs/day or near constant performance (too numerous to count) |

Cross check

Case studies, page 51

Now test yourself

- 15 Describe **one** way in which obsessive-compulsive disorder has been measured using a questionnaire.

Answer on p. 198

Tested

- The MOCI and YBOCS questionnaires gather **quantitative data**, and the YBOCS has the option via **interviews** to gather **qualitative data**. (*Strengths and weaknesses for all.*)
- Both questionnaires claim that they are **reliable** and **valid** because they are **psychometric**. (*Strengths and weaknesses for all.*)
- These tests may have **cultural bias** (*weaknesses*).
- The **case study** of Charles and example of Kayla have strengths and weaknesses.

Cross check

Types of data (quantitative and qualitative data), page 60
Interviews, page 50
Psychometric tests, page 89
Questionnaires and ratings, page 49
Case studies, page 51

Explanations of obsessive–compulsive and related disorders

Biological (genetic, biochemical and neurological) explanations: studies on genetics have shown that the SLITRK family of genes is linked to aspects of OCD. Studies have linked SLITRK1, SLITRK3 and SLITRK5 to OCD in mice. Other studies show the gene PTPRD is also linked, along with DRD4, a dopamine receptor.

Biochemical explanations have been proposed. The hormone oxytocin has been associated with aspects of OCD and Humble et al. (2011) found that levels of oxytocin positively correlated with OCD symptoms.

Neurological studies have shown that people with OCD show abnormal functioning in the orbital region of the frontal cortex and/or the caudate nuclei. These regions are responsible for converting sensory input into thoughts and behaviours, and if these regions do not regulate activity (e.g. they become over-stimulated), this could account for the recurring thoughts and behaviour. Evidence for this is gained from brain scans and studies of people with brain injury in these regions (e.g. Paradis et al., 1992).

Cognitive and behavioural explanations: the behavioural explanation suggests that people associate a particular ‘thing’ with fear and so they learn to avoid that ‘thing’ and perform ritualistic behaviour (the compulsion) to help reduce the anxiety and fear. The cognitive side looks at why people misinterpret their thoughts associated with the ‘thing’ and how these become obsessive.

Psychodynamic explanations: the psychodynamic explanation of OCD follows the same principles as with other mental disorders: there is a conflict between the id and the ego, which creates anxiety. The impulsive nature of the id may be responsible for the creation of obsessive thoughts, while the ego, in an attempt to control the id, may create compulsive behaviour to try to counteract the obsessive thoughts and resolve the conflict.

Psychoanalytic psychotherapy encourages the verbalisation of all the patient’s thoughts, including free associations, fantasies and dreams, from which the analyst formulates the nature of the unconscious conflicts which are causing the patient’s symptoms and character problems.

Evaluation

- All the approaches here are **reductionist** (*strengths and weaknesses*).
- The **nature–nurture debate** (*strengths and weaknesses*) applies because genetic and psychoanalytic explanations are nature and behavioural explanations are nurture.
- Behavioural approaches emphasise **environmental determinism** whereas biochemical approaches emphasise **biological determinism**.

Cross check

Reductionism, page 89
Nature–nurture debate, page 75
Determinism, page 90

Treatment and management of obsessive–compulsive and related disorders

Biomedical treatments assume that if OCD is caused by low serotonin levels, then drugs can be used to increase the activity of serotonin in the brain. This is exactly what clomipramine does. About 60% of patients with OCD improve

12 weeks. Of those patients who do respond, at least 75% will relapse in the months after stopping the drug.

Psychological treatments

Cognitive-behaviour therapy (CBT) is a mixture of cognitive and behaviour therapies combined because behaviour often reflects thoughts about certain things or situations. Research by **Lovell et al.** (2007) aimed to compare the effectiveness of CBT delivered by telephone with the same therapy given face to face in the treatment of OCD. Seventy-two patients diagnosed with OCD were randomly given either face-to-face therapy (ten 1-hour sessions) or 'telephone' therapy (initial face-to-face therapy then eight 'home/telephone' sessions of 30 minutes' duration and one face-to-face final session). The study concluded that cognitive-behaviour therapy delivered by telephone was equivalent to treatment delivered face to face and similar levels of satisfaction were reported by patients.

Exposure and response prevention (ERP): *exposure* means facing or confronting the feared stimuli and/or situations repeatedly until the fear associated with them subsides, and *response prevention* means not carrying out the compulsive, avoidant or escape behaviour. ERP targets the behavioural component of CBT.

Lehmkuhl et al. (2008) reported on the use of ERP to treat a 12-year-old boy with OCD with autism, an autistic spectrum disorder (see page 20). Jason experienced contamination fears, avoiding 'contaminated' items (e.g. door knobs, library books, etc.). He would not sit on chairs, turn pages with his hands, or touch papers that other children had touched. Jason reported significant anxiety when prevented from completing his rituals (e.g. hand washing, using hand sanitiser) and this began interfering with his everyday functioning. Jason spent several hours per day at home washing his hands or worrying about potentially contaminated items throughout the house. In early therapy sessions, Jason was required to touch items in the hospital such as elevator buttons and door handles until his anxiety was much reduced. When touching, Jason had to repeat coping statements such as 'I know that nothing bad will happen.' Jason even reported being proud of himself when exposures were successfully completed. In later sessions other feared stimuli were targeted, also with success.

Evaluation

- The **case study** of Jason has strengths and weaknesses.
- Biomedical treatments are **reductionist**, are **nature** rather than **nurture** and are **deterministic**. (*Strengths and weaknesses of all.*)
- CBT (and ERP) are based on the **learning approach** and **nurture**. (*Strengths and weaknesses of both.*)

Strengths and weaknesses of drug treatments, page 96

Now test yourself

- 16 Describe the assumptions of cognitive-behavioural therapy regarding obsessions and compulsions.

Answer on p. 198

Tested

Expert tip

Prepare an exam-style essay on obsessive-compulsive and related disorders. For part (a), the 'describe' part, decide what you need to include (and exclude). In the exam, you should spend no more than 12 minutes on this part. For part (b), the 'evaluate' part, choose a range of issues to include (three is a range). Choose two issues in addition to the named issue. You should spend no more than 18 minutes on part (b).

Cross check

Case studies, page 51
Nature-nurture debate, page 75
Reductionism, page 89
Determinism, page 90

5.3 Psychology and consumer behaviour

The physical environment

Revised

Retail/leisure environment design

The term '**retail atmospherics**' refers to all of the physical and psychological elements of a store that can be controlled in order to enhance (or restrain) the behaviour of both customers and employees (Eroglu and Machleit, 1993).