REVIEW OF OBSESSIVE COMPULSIVE DISORDER: ORIGINS, SYMPTOMOTOLOGY, AND INTRODUCTION TO TREATMENTS

A dissertation submitted to the Wright Institute
Graduate School of Psychology, in partial fulfillment of the requirements for
the Degree of Doctor of Psychology

by
VANESS PAUL BRIM
NOVEMBER, 2003

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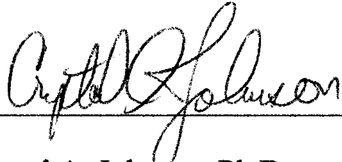
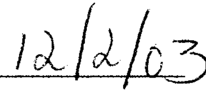

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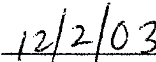

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REVIEW OF OBSESSIVE COMPULSIVE DISORDER:
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Obsessive-Compulsive Disorder affects approximately 1-2% of the population worldwide. Obsessions are recurrent thoughts, impulses, or images that are experienced as intrusive, and anxiety provoking. Compulsions are repetitive behaviors such as hand washing, checking, or organizing, and are employed to control undesirable obsessions. Obsessive-Compulsive Disorder and Obsessive-Compulsive Personality Disorder are separate diagnoses. However, there is an argument that indicates some dynamic relationship. This paper discusses the theories of etiology and treatment of OCD from the perspectives of biopsychology, cognitive behavioral psychology, and psychodynamic/ psychoanalytic psychology. Effective treatment will typically involve multiple approaches given the complexity of this disorder.

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Introduction

Currently, Obsessive-Compulsive Disorder (OCD) affects approximately 1%-2% of the population, and is more common than schizophrenia or panic disorders. The onset is usually at adolescence, but affects individuals of a variety of ages. As the name indicates, there are two components to this disorder. Obsessions are recurrent and persistent thoughts, impulses, or images that are experienced as intrusive, inappropriate and anxiety provoking. Compulsions are repetitive behaviors such as hand washing, checking, and organizing. For the OCD patient, the relationship between obsessions and compulsions is complementary. The compulsive behaviors are employed in an effort to control the undesirable obsessions.

Theories on the causes of OCD are intriguing. Biopsychologists can use brain-imaging techniques to locate abnormalities in regions specific to OCD. Cognitive behaviorists believe the disorder to be a result of cognitive misperceptions, while psychodynamic/psychoanalytic perspectives attribute symptoms to unconscious process and internal conflict management. There is some controversy as to whether or not Obsessive-Compulsive Disorder and Obsessive-Compulsive Personality Disorder (OCPD) are related. Although they are recognized as separate and distinct disorders by the Diagnostic and Statistical Manual of Mental Disorders-IV (1994), they have many similarities.

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An attempt to gain knowledge about the causes and appropriate treatments for OCD can be an arduous task. Biopsychologists, cognitive behavioral therapists, and psychodynamic/psychoanalytic therapists all have compelling arguments for the etiologies and treatments for OCD. However, there is little effort in the literature to explore multidetermined etiologies and multimodal treatments. The ideas from each of these disciplines are often presented independently, with concepts that lack bridges to one another.

To date, empirical evidence supports cognitive behavioral treatment with medication as an effective approach for OCD, yet such findings may be deceiving. Meanwhile, the deficiency of contemporary analytic contributions on OCD remains disappointing. To further complicate matters, most of the analytic literature addresses OCD as a manifestation of the character disorder (OCPD), failing to differentiate the two as does the DSM-IV. Future progress by the analytic community is needed.

While it may appear that there is little support in the literature for the dynamic therapist treating the OCD patient, therapists of the psychodynamic/psychoanalytic discipline are typically well suited to diagnose the patient, taking into consideration the complexities of each individual case. With this, the dynamic therapist can recommend or provide a treatment, or combination of treatments most appropriate.

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Review of Literature

OCD by Definition and Symptoms

According to the Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition (1994), (DSM-IV), the definition for Obsessive Compulsive Disorder is best summarized by separating its complementary components, obsessions and compulsions, and providing an essential description of each.

Obsessions are described as follows:

> Obsessions are persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress. The intrusive and inappropriate quality of the obsessions has been referred to as "ego-dystonic." This refers to the individual's sense that the content of the obsession is alien, not within his or her own control, and not the kind of thought that he or she would expect to have. However, the individual is able to recognize that the obsessions are the product of his or her own mind and are not imposed from without (as in thought insertion). (p. 418)

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Obsessions are usually related to contamination by dirt or perceived disease (e.g., fear of germs after physical contact with someone); repeated doubts (wondering whether the stove is off, or door locked, etc.); a need to have things in an orderly fashion that is often specific (e.g., intense distress when objects are disordered or asymmetrical, example: a fork turned the wrong way in the silverware drawer) or aggressive or sexual impulses (such as disturbing violent or pornographic imagery). These thoughts, impulses, or images are excessive and not realistically related to life problems such as school or work.

The DSM-IV (1994) describes compulsions as follows:

> Compulsions are repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently), the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification. In most cases, the person feels driven to perform the compulsion to reduce the distress that accompanies an obsession or to prevent some dreaded event or situation. By definition, compulsions are either clearly excessive or are not connected in a realistic way with what they are designed to neutralize or prevent. (p. 418)

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For example, individuals with obsessions about being contaminated by germs or disease may reduce their anxiety by washing their hands repeatedly or for long durations, sometimes until their skin is raw. Individuals distressed by obsessions about having left a door unlocked would likely check the lock repeatedly. Others distressed by unwanted profane thoughts may find relief from their anxiety by incorporating thought blocking techniques such as counting or praying. In some cases, individuals perform acts according to particular, elaborate, self-invented rules without being able to indicate why they are doing them.

According to Baer and Jenike as cited in Gabbard (1994), complaints of Obsessive-Compulsive patients fit into five primary categories: 1) rituals involving checking, 2) rituals involving cleaning, 3) obsessive thoughts unaccompanied by compulsions, 4) obsessional slowness (hypervigilance for ordinary tasks), and 5) mixed rituals. OCD is often complicated by depression, and impairment in interpersonal and occupational functioning. Family members are usually significantly affected by the patient's illness as well.

Some people with OCD actually fear that they have already harmed or killed someone accidentally or unconsciously, and are in constant anxiety over the question, "How do I know that I did not hurt or kill someone? I can't be too sure." For example, a driver with OCD may hit a pothole and suddenly become overtaken with fear that he or she had actually run over someone. Not able to be

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sure enough, he or she would then continue to drive back and forth around the site looking for an injured person. For others, OCD manifests itself with counting. Toes or fingers may have to be tapped a specific number of times, a certain number of basketball shots would have to be successfully made in succession, or objects would have to be counted repeatedly to be certain of no mistakes (Kolata, 1995).

The DSM-IV states that at some point during the course of the disorder, the individual has recognized that his or her behavior has become unreasonable (this does not apply to children). The obsessions or compulsions cause marked distress, consume more than one hour per day, and significantly interfere with the individual's normal routine or lifestyle.

Onset for OCD symptoms is typically gradual. For males, modal age onset is between the ages of 6 and 15 years and for females, between 20 and 29 years of age (DSM-IV, 1994). More often than not, obsessive-compulsive symptoms first appear in adolescence or early adulthood, yet have been reported in children of preschool age as well as in senior adults.

Presentations of obsessive and compulsive symptoms are similar in children, adolescents, and adults. Washing, checking, and ordering are the most common compulsions observed. Children usually do not experience their symptoms as ego-dystonic and are typically brought in for treatment by their parents or guardians. Poor concentration and a decline in academic performance

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are usually noted. Individuals of any age with OCD will be more likely to engage in compulsive rituals in the privacy of their homes instead of in front of teachers, peers, or strangers.

The following is a brief summary of a clinical case illustrating the symptom manifestation for OCD, borrowed from Kolata (1995):

Mary Hill, a 33 year old artist in Plano, Texas, reported that she would wash her hands as a child to get rid of not only germs, which she thought would contaminate people she loved, but also bad thoughts. When she washed, she would say a prayer, thanking God for every person in the family. She had seven siblings and believed that whomever she named last in her recitation would die or be harmed. When she got to the end of the list, she would start the prayer over, naming the last person first.

Soon, Hill began elaborating on her ritualistic behaviors. She began flicking water around the bathroom to chase the bad thoughts or germs into the air, then wiping the room down again while inhaling and exhaling the evil ruminations. She eventually became so overtaken by her fixations, that she could not hold a conversation or even watch TV. She would appear to be doing homework, but in actuality, she would be focused on her obsessions. Her friends and family thought that she was spacey, and strange, not knowing about her OCD. She tried to cover for her strange behavior by making jokes of it.

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When Hill married and had children, she would have paralyzing fears that she would be unable to prevent herself from killing them. She visualized stabbing her child or stuffing her into the microwave. Hill shocked herself with the violence of her own thought patterns. She considered herself a terrible person.

The above case depicts symptomology of a more severe case of Obsessive-Compulsive Disorder. OCD does not make an individual violent, but can instill the unrealistic fear that the individual may spontaneously become violent and commit a heinous act. As illustrated, obsessive thoughts can become quite consuming, while compulsive rituals are used to alleviate anxiety caused by the obsessions.

To summarize, the DSM-IV provides a useful standard for defining OCD. Obsessions are invasive, intolerable thoughts or images. An obsessive-compulsive engages in compulsive activities in order to quash the obsessions. Compulsions are ritualistic physical or mental activities with themes usually related to washing, checking, or ordering. The onset of Obsessive-Compulsive Disorder is typically during adolescence or early adulthood, but has been noted to occur at a variety of ages.

OCPD by Definition and Symptoms

Obsessive-Compulsive Disorder and Obsessive-Compulsive Personality Disorder frequently appear in literature as undistinguished from one another. "Although a distinction has increasingly been drawn between OCD and OCPD,

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their relationship has been a subject of considerable debate and has not yet been fully resolved" (Stein and Stone, 1997, p. 6). Provided is a summary of salient aspects of the definition for Obsessive Compulsive Personality Disorder borrowed from the DSM-IV (1994):

> The essential feature of Obsessive-Compulsive Personality Disorder is a preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency. This pattern begins by early adulthood and is present in a variety of contexts. (p. 669)

Individuals with Obsessive-Compulsive Personality Disorder attend to minute details in an effort to control others and their environment. Concern with such details becomes the task while the original purpose of the activity is lost. Those with the personality disorder tend to be oblivious to the effect they have on others while they ruminate over details. They may continue to frustrate others by failing to allocate appropriate time for tasks and are typically late for deadlines and appointments. They are often unable to complete tasks due to a feeling that their work is never good enough. Individuals with OCPD spend little time in leisure activity. Leisure is often difficult or awkward, unless structured around a task such as a sport.

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> Obsessive-Compulsive Personality Disorder may cause individuals to be excessively conscientious, scrupulous, and inflexible about matters of morality, ethics, or values. They may force themselves and others to follow rigid moral principles and very strict standards of performance. They may also be mercilessly self-critical about their own mistakes. Individuals with this disorder are rigidly deferential to authority and rules and insist on quite literal compliance, with no rule bending for extenuating circumstances. For example, the individual will not lend a quarter to a friend who needs one to make a telephone call, because "neither a borrower or lender be" or because it would "bad" for the person's character. These qualities should not be accounted for by the individual's cultural or religious identification. (DSM-IV, 1994, p. 670)

Individuals with OCPD may hoard objects such as newspapers, magazines, broken, and worn-out items having no sentimental value. They may justify their actions with the idea that such items will likely be needed someday and should not be wasted today. Overwhelming stacks of debris in living and working spaces sometimes reach dangerous proportions, causing fire hazards. An individual with OCPD is likely to become very upset with anyone who tries to

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discard such a collection of items, placing strain on relationships. Others working or living with someone with OCPD may experience high levels of frustration due to their controlling nature and hypervigilance.

Individuals with OCPD often over-burden themselves with responsibilities for tasks. They typically have very specific routines for performing tasks and are quite rigid in opinion about how they should be executed. For example, if a job were behind schedule, it would probably go unfinished before help was accepted due to the belief that no one else would do it "right". If help were accepted, it would likely be met with specific demands that may offend the helper at hand. The individual with OCPD would likely be surprised and irritated by suggestions for alternative methods of completing tasks. Individuals with OCPD also may have difficulty deciding which tasks take priority, how to sequence them, and how to perform them. This often leads to the inability to get any tasks started.

Individuals with OCPD also tend to have difficulty expressing emotions openly. They are typically uncomfortable around others who are emotionally expressive. Social interactions tend to be rather stiff and serious. They have difficulty feeling connected to others in a satisfying manner. They are unlikely to pay compliments to others.

Finally, an individual with OCPD may be quite miserly, living far below the standard of life that he or she could reasonably afford. The fear that money will be needed for a "rainy day" usually underlies this behavior. Others socially

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connected to the OCPD individual consider such levels of stubbornness and rigidity unreasonable.

The diagnostic criteria for OCPD are lengthier in description than for OCD with a focus on interpersonal dynamics and resulting difficulties. These interpersonal components are the salient features that qualify it as a personality disorder and help to differentiate OCPD from the Axis I disorder, OCD.

OCD vs. OCPD

There are two key differences between Obsessive-Compulsive Disorder and Obsessive-Compulsive Personality Disorder. First is the presence of true obsessions and compulsions in OCD. Second is the patient's subjective experience of symptoms as ego-dystonic in OCD or ego-syntonic in OCPD. However, the relationship between OCD and an obsessive personality remains somewhat controversial. According to the DSM-IV, some studies suggest an association between Obsessive-Compulsive Disorder and Obsessive-Compulsive Personality Disorder. The DSM-IV also states that the majority of individuals with OCD do not have a pattern of behavior that meets criteria for OCPD.

The DSM-IV (1994) differentiates OCD from OCPD as follows:

> Obsessive-Compulsive Personality Disorder is not characterized by the presence of obsessions or compulsions and instead involves a

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> pervasive pattern of preoccupation with orderliness, perfectionism, and control and must begin by early adulthood. (p. 422)
>
> When criteria for both disorders are met, both diagnoses should be recorded. (p. 671)

While the DSM-IV distinguishes OCD from OCPD quite plainly, much of the psychoanalytic literature does not. There has been an historical tendency to place OCPD and OCD on the same continuum (Gabbard, 2001), yet others support the notion that OCD is differentiated from OCPD. Evidence supporting each side of this paradigm will be reviewed, and some conclusions will be drawn.

First, it may be argued that Obsessive-Compulsive Personality Disorder can lay the groundwork for the development of Obsessive-Compulsive Disorder. This perspective asserts that a predisposition to neurotic tendencies or defenses can lead to the development of OCD. An underlying personality structure that is prone to creating particular defenses against anxiety (found in those with OCPD) may resort to regressive neurotic defenses (as found in OCD) when anxiety levels become uncontrollable.

> It has been commonplace of psychoanalytic thought on the subject that obsessive-compulsive disorder (or frequently called obsessive-compulsive neurosis in psychoanalytic

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> literature) is developmentally and structurally allied to obsessive-compulsive personality. The emergence of the neurotic syndrome (OCD) represents, in this view, a breakdown and regressive reintegration of the underlying personality structure. (Esman, 2001, p. 328)

This position suggests that obsessive-compulsives have a likelihood of premorbid personality characteristics found in OCPD. However, since Obsessive-Compulsive Personality Disorder cannot be diagnosed in children (as it is customary not to diagnose personality disorders in patients prior to adulthood) and that Obsessive-Compulsive Disorder usually has an onset in adolescence, it is often difficult to measure OCPD as a precursor to OCD.

Salzman (1985) and Mallinger (1984) suggest that OCD is used as a method for satisfying a patient's need for control in all aspects of life, often developing early in childhood. Undesirable obsessions can be controlled with compulsions, preventing images and thoughts that would otherwise produce feelings of shame or guilt. Such feelings would likely stem from obsessions that include sexuality and aggression. Both of these authors support the notion that there is not a large discrepancy between the obsessional character and obsessive-compulsive neurosis, but instead that they exist together on a spectrum. The neurosis is the outcome of a breakdown of the adaptive defenses leading to the

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mobilization of secondary pathological security measures. Developmentally, the OCD may come into play in order to satisfy a need for greater control and safety when external dangers and parental inconsistency were problematic.

Shapiro (2001) believes that compulsive symptoms are particular products of the mind, derived from a subjective state. The subjective experience of symptoms from both OCD and OCPD are analogous, arising out of a particular kind of character organization. Both OCD and OCPD are found in individuals who tend to be highly self-critical, featuring harsh and overpowering superegos. The superego is a conceptual part of the mind that evaluates and judges by reasonable standards in healthy individuals. For those with OCD or OCPD, the superego is hypercritical and overly judgmental. A patient with either disorder will likely feel an intense level of anxiety associated with a lack of perfection, order, or purity.

An unrealistic sense of responsibility for safety is a common factor for patients with either disorder. Anxiety is usually brought about by a perceived lack of control for a particular outcome, i.e., perceived impending harm to one's self or to others. In either case (OCPD or OCD) the individual will experience an intolerable sense of responsibility to control outcomes. The individual takes action in the form of controlling or compulsive behavior in an effort to reduce this terrible anxiety.

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Other psychoanalytic contributions in the literature see less of a correlation between OCD and OCPD. Esman (2001) reviews the work of Insel who states explicitly that obsessive-compulsive disorder is not a severe form of obsessive-compulsive personality disorder. According to Insel, between 16 percent and 36 percent of patients with the neurosis (OCD) do not have premorbid obsessive traits. In fact, an obsessive-compulsive personality tends to decompensate not into the neurosis (OCD), but into depression. So, instead of showing signs of the classic anal triad of orderliness, obstinancy, and parsimony, the premorbid personality of the patient with OCD is likely to be cautious, introverted, and non-aggressive. "A substantial proportion of patients with obsessive-compulsive disorder do not show the classical obsessional or "anal" character premorbidly, and the common clinical observation is that obsessional characters typically develop depressive rather than obsessional-neurotic symptoms" (Esman, 2001, p. 331).

Flament and Rapoport (1984) concurred with respect to children. They found that very few of their OCD patients were particularly clean and orderly, nor did they manifest the "anal triad". Instead, they typically were found to be shy and non-aggressive. Interestingly, on follow-up there were more obsessive-compulsive personality diagnoses than at baseline. Their findings suggest that Obsessive-Compulsive Disorder might be partly responsible for the pathogenesis of Obsessive-Compulsive Personality Disorder instead of the reverse.

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Gabbard (2001) believes that Obsessive-Compulsive Disorder and Obsessive-Compulsive Personality Disorder are fundamentally different. Only approximately 6 percent of OCD patients also have OCPD. He contends that OCPD is highly responsive to psychoanalytic treatment, and states that there is a growing body of evidence showing that OCD is not necessarily responsive to psychoanalytic treatment. He believes that the lack of response in analytic treatment of OCD suggests a stronger argument for biological factors.

It seems reasonable to conclude that OCPD and OCD share some similarities. The subjective experience of a patient with either disorder is chronic anxiety with the sense of unrealistic omnipotence and responsibility. It is this omnipotence and responsibility that are both the problem and solution for the patient in either disorder. Patients feel an overwhelming and frightening sense of power, accountability and impending guilt for perceived danger to themselves and to others. They utilize the same sense of omnipotence with a rather unrealistic belief that they can control outcomes in real world events. Patients with OCD and OCPD control their internal worlds with fervor. Conscientious, prefabricated ideologies dominate the mind and abate any intrusive ideas or feelings that may threaten or compete with the manipulated versions of their internal realities.

Both OCPD and OCD patients will likely suffer from chronic anxiety, fearing impending guilt and shame. Ironically, in either case, one might view the superego as a mechanism to *save* the patient from his/her own perceived demise.

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In other words, the superego keeps the individual's thoughts and actions in check with great scrupulosity in order to comply with what is perceived as a harsh and demanding external world. The superego is not providing internal torment and punishment as much as it is working to *prevent* imagined external judgment and punishment.

Along with these similarities, distinctions remain. A primary difference between Obsessive-Compulsive Personality Disorder and Obsessive-Compulsive Disorder is that the symptomology of OCPD is shared interpersonally while that of OCD is experienced in greater isolation. OCD and OCPD may have markedly different presentations to the objective observer. The individual with OCD will work to hide his or her symptoms from others. One with OCPD will incorporate relationships with others into his or her symptom constellation, resulting in interpersonal tensions.

Efforts to determine whether or not OCPD can evolve into OCD are unlikely to prove fruitful. Likewise, efforts to distinguish OCPD from OCD are rather, well...obsessive. OCD can develop without signs of OCPD and vice versa. Either one of the two disorders can evolve into the other, or they can coexist. "Neither Axis I nor Axis II disorder is primary to the other. The disorders may arise from a common cause, or they may have independent etiologies, but nevertheless interact in important ways" (Stein, Hollander, and Skodol, 1993, p. 88). When diagnosing OCD and making an attempt to decipher

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it from OCPD, a therapist is well advised to look for evidence of both, holding a space in mind for such a possibility.

To conclude, the DSM-IV clearly states the factors distinguishing Obsessive-Compulsive Disorder from Obsessive-Compulsive Personality Disorder within a psychiatric perspective. Primarily, OCD is diagnosed when obsessions and compulsions are present. OCPD is diagnosed when the preoccupations with orderliness, control, and perfectionism persist. Competing theories suggest that the distinction is not so clear and that significant similarities exist. It is reasonable to conclude that these two disorders cannot be sharply delineated, as the DSM-IV would suggest.

Prevalence

Currently, Obsessive-Compulsive Disorder affects approximately 1%-2% of the population worldwide. OCD is found across a large spectrum of cultures and is more common than schizophrenia or panic disorders. As reported by Osborne (1998), the first large scale study of the rate of occurrence of mental health disorders in the United States was completed by the National Institute of Mental Health (NIMH) in 1983. Researchers went from door to door in different areas of the country interviewing 18,500 randomly selected people. OCD had a surprising occurrence of 1.3% to 3.3%. However, there is general agreement that the occurrence of OCD is in the 1%-2% range. About 80% of sufferers of OCD

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experience both obsessions and compulsions. The remaining 20% cope with either obsessions or compulsions (Dumont, 1996).

Causes

The etiology of Obsessive-Compulsive Disorder is debatable. The advent of brain imaging technology has brought significant contributions to a greater understanding of this disease. Theoretical offerings from the cognitive perspectives and classical psychodynamic/psychoanalytic theories also continue to help elucidate the etiology of OCD. Some of the more prominent theories from biopsychology, cognitive, and psychodynamic/psychoanalytic approaches to the etiology for OCD will be summarized in this section.

Biopsychological Theories. Recent developments in the field of biopsychology have provided significant advances in understanding and treating OCD. Before 1980 there was no way to measure regional biochemical reactions as they occurred in the brain (Osborne, 1998). More recently, techniques such as positron emission tomography (PET), single-photon emission computed tomography (SPECT), and magnetic resonance imaging (MRI) can perform continuous surveys of chemical reactions in the brain and display them on screen. In both PET and SPECT, investigators label a substance with a radioisotope, inject it into the bloodstream, and then observe where the isotope shows up in the brain. Radiation detections provide the visual evidence for brain activity. In PET (the most widely used technique) the labeled compound is usually sugar, the sole

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source of brain cell nourishment. The areas that light up on the PET scan screen are the brain regions that are absorbing the most sugar, those that are working the hardest.

The MRI measures images in the brain by calculating the energy that is emitted by subatomic particles. There is a clear advantage to the use of the MRI in that it involves neither radiation nor the drawing of blood. In addition, it is proving to be the most sensitive and versatile of brain imaging techniques.

Brain imaging techniques have played a key role in pinpointing areas of the brain involved in OCD. Among biopsychologists and neuropsychiatrists, there is a broad consensus that brain circuitry contained within the orbital frontal cortex (OFC), anterior cingulate gyrus, and the basal ganglia is intimately involved in the expression of the symptoms of OCD (Schwartz, 1999). Utilization of PET and functional MRI scans has illustrated changes in cerebral activity after acute symptom exacerbation in patients with OCD. This was achieved by exposing OCD patients to stimuli, which elicit the intrusive thoughts and urges (obsessions and compulsions). The result was increased activity in the OFC and the anterior cingulate gyrus evidenced by the scans. According to Schwartz, these are

> brain regions with a well demonstrated capacity to generate
> alerting error detection type signals in response to

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> unanticipated alterations in the environment, as well as in the caudate nucleus, a key component of the basal ganglia and the major sub-cortical projection site involved in the functional modulation of the OFC and cingulate. (p. 119)

OCD sufferers show unusually high levels of activity in the OFC and basal ganglia even at rest. During the performance of compulsive rituals, the brain activity is further intensified as verified by the scan. But what has caused the abnormal brain activity in the obsessive-compulsive is a question left unanswered.

There is some evidence suggesting that OCD can be a result of exposure to long-term traumatic stress, which generates an unusually high level of anxiety during psychological development in the premorbid OCD child. A child evolves a distinct cognitive style in response to aversive conditions. In the case of OCD, this cognitive style is characterized by exaggerated threat appraisal and magical beliefs. Alterations in brain metabolism occur as a result.

> An entire functional brain system (basal ganglia-orbitofrontal circuit) enters into a state of enhanced responsiveness following exposure to protracted threat. Over time the threshold for stimulation is dramatically lowered, resulting in a hypersensitivity to cues that signify

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> potential harm. Individuals adapt to this hypersensitivity through a variety of strategies, which constitute OCD. (Dinn, Harris, and Raynard, 1999, p. 313)

Suggested is a relationship between psychosocial trauma and orbitofrontal hyper-metabolism in OCD patients as a cellular response to long-term stress. "The orbital cortex contains a region that is responsive to any form of intense and prolonged noxious stimulation" (Dinn, Harris, and Raynard, 1999, p. 321). Trauma-induced sensitization can lead the human brain to become developed and shaped (in part) according to the environment.

Some individuals may be prone to developing Obsessive-Compulsive Disorder due to a biological predisposition. Eric Hollander, as cited in Kolata (1995), states that OCD tends to run in families and has nothing to do with the culture in which patients are raised. About the same proportion of people in the United States, Europe, Africa, and Asia have the troubling illness. One possible explanation is that there may be biological factors that predispose an individual to experiencing anxiety in greater acuity than others would. The development of OCD may be in response to this biological predisposition (Dinn, Harris, and Raynard, 1999). For example, an individual with such a predisposition may respond to the idea of germs with an overly exaggerated fear that they are detrimental or fatal.

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For the obsessive-compulsive, escalated fears and phobias or other preoccupations with safety may be due in part to the genetic inheritance of survival tactics. Some researchers have explored the idea that animals have inherent "hardwired" behaviors to insure survival. Dutch ethologist Nickolaas Tinbergen found that chicks of certain species react in fear when exposed to silhouettes that resemble shadows of their natural predators. These chicks were raised in isolation and had never before seen predatory birds. They became very agitated when exposed to shapes resembling hawks, but did not react to shapes representing non-predatory birds. Knowledge of the threatening shapes appears to be genetically hardwired into their brains, creating fear responses without the need to learn from experience.

Similar genetic inheritance may be of significance in the innate fears that become exaggerated in certain human phobias (Barondes, 1999). The idea is that humans are born with a genetic bias to maintain personal safety in order to help insure survival. There is far less at risk if an organism invests in extra precaution as opposed to letting down guard and chancing harm. "Anxiety disorders are thus to be understood as exaggerated or inappropriate forms of adaptive strategies" (Stevens and Price, 1996, p. 98). Higher-level brain functioning works to strategize for safety. Once the reliability of an avoidance tactic is established, it is difficult to change (Barondes, 1999). In the case of the obsessive-compulsive, preoccupations with safety may be due in part to the genetic inheritance of these

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survival tactics, then reinforced through practice over time as the individual is convinced that the obsessive-compulsive symptoms are actually preventing danger.

Brain imaging techniques are providing clues, isolating brain dysfunction to particular areas of the brain in OCD patients. The obsessive-compulsive may be biologically and/or genetically predisposed to developing brain neuropathways in response to an environment that is perceived as an extreme and chronic threat. OCD may be a result of adaptations created to cope with the anxiety generated by these threats.

Cognitive Theories. Cognitive theory conceptualizes Obsessive-Compulsive Disorder in terms of schemas, negative automatic thoughts, and erroneous beliefs (sometimes called false beliefs or cognitive misperceptions). A schema can be understood as one of many theories an individual holds for how the world works (Fadiman and Frager, 1994). Schemas are expectation-driven, unconscious, automatic perceptions of reality. For example, a child who experiences consistent love and support from her parents may develop a schema that people who love her can be relied upon for support, and/or she is valued and worthy of the positive attention.

The use of schemas can be adaptive, but sometimes schemas can go awry and create mismatches between perception and the reality of what the environment actually offers (Fadiman and Frager, 1994). For example, a child

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who is physically and emotionally abused by her parents may develop a schema that care givers cannot be trusted, and/or people whom she loves will hurt her reliably, and/or she is deserving of such punishment because she is inherently bad. Although such schemas may be adaptive within the context of her family, when applied to the outside world, difficulty in relationships is almost certain. She will likely believe that danger and harm are to be expected from others, perceiving most interactions as potentially threatening. The possible varieties of maladaptive schemas are endless. As one might expect, various levels of anxiety can be created as a result of living in a world perceived as threatening.

A variety of defenses may be developed by an individual coping with maladaptive schemas, including obsessive-compulsive symptoms. A likely contributor to the development of Obsessive-Compulsive Disorder would be a schema that an individual is omnipotent. A schema that enforces the idea that an individual has unrealistic control over others creates an anxiety provoking sense of responsibility. At times, schemas of omnipotence are developed and reinforced by reality. For example, a child who is abused may try to influence ways that a parent may respond. In the face of danger, he will systematically develop methods or behaviors that would be less likely to cause his parent(s) to respond with anger and violence. Alternatively, he will become aware that he has significant influence and can create such negative reactions in the parent(s). The child will learn that he can control his parents and becomes burdened with the

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responsibility to insure peace and comfort in the family. He may clean his room compulsively in effort to control his mother's or father's temper(s).

Furthermore, a schema of omnipotence would lead a child to believe that he can magically control the positive or negative outcomes of real world events by use of his wishes and thoughts. With this sense of control comes the responsibility to insure these outcomes are favorable. For example, if a child wishes his father were dead, he may believe that his wishes can cause his father to actually die. As a result, feelings of resentment, rage, or wishes of death directed at his father will become extremely dangerous and anxiety provoking, and are forced out of consciousness. This cognitive material can resurface in the form of obsessions, i.e. images of violent acts against the father, or images of his dead body. In order for these thoughts and wishes to be forced out of awareness, they require compulsions to prevent them from re-entering the stream of thought.

Supporting problematic schemas are negative automatic thoughts, which mark another key concept as part of the pathogenesis of OCD. Unlike schemas, negative automatic thoughts are experienced consciously. They typically go unquestioned by the individual experiencing them and are simply accepted as true, "I must be a filthy person if I have intrusive thoughts about sex." For the OCD patient, these negative automatic thoughts are the response to obsessions. They are punitive evaluations of one's self typically based on erroneous beliefs (Barlow, 1993). The castigatory assessment of the obsession ("experiencing

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obsessions about sex means I am filthy") contributes to the need to keep such material from entering consciousness. Compulsions are used to quash the obsessions.

Erroneous beliefs are false ideas held by many obsessive-compulsives and are used as reasoning to maintain OCD symptoms. Consistent for most obsessive-compulsives is the belief that magical rituals can prevent catastrophes. Salkovskis (1985) proposed five erroneous beliefs that characterize obsessive-compulsives.

> 1) Having a thought about an action is like performing the action; 2) failing to prevent (or failing to try to prevent) harm to self or others is the same as having caused the harm in the first place; 3) responsibility is not attenuated by other factors (e.g., low probability of occurrence); 4) not neutralizing when an intrusion has occurred is similar or equivalent to seeking or wanting the harm involved in that intrusion to actually happen; 5) one should (and can) exercise control over one's thoughts (p. 579).

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Responsibility and self-blame are central themes in most of the above erroneous beliefs and are often found in the symptom structure of the obsessive-compulsive (Barlow, 1993).

Under a cognitive model, the contributing factors for the development of OCD would include a schema of omnipotence (for example). The individual will likely experience negative automatic thoughts regularly in response to obsessions and experience the need to eliminate them by using compulsions. Erroneous beliefs lead to distress as a result of an over inflated sense of responsibility for harm. The obsessive-compulsive believes he can magically neutralize the potential for harm through compulsions, which are intended to make things right or to avert the possibility of being responsible for some feared result.

Psychodynamic/Psychoanalytic Theories. Authors of the psychodynamic/psychoanalytic perspectives of Obsessive-Compulsive Disorder view OCD symptoms as an attempt to manage conflict and unconscious anxiety. Most consider obsessions and compulsions to be instigated by a harsh superego, a theoretical component of the mind that represents an overly critical internal voice for the OCD patient. Unfortunately, the body of contemporary literature covering analytic concepts for OCD is rather impoverished. Many contributions are elaborations on Freud's earlier ideas of the basic conflicts and defenses of the obsessional character. This section will briefly cover some of the dominant classic analytic theories as well as essential contemporary concepts.

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Freud developed an hierarchal, three-part model of the psyche consisting of the id, ego, and superego. He believed that the individual is born without an ego intact. An infant experiences sensations, impulses, and drives. The ego is developed over time in order to mediate between the id's drives and impulses, and external reality. The superego eventually develops as a governing voice, casting moral judgment on the ego in order to comply with perceived social reality.

In the case of the OCD patient, Freud declared the

> superego of the individual with obsessive-compulsive disorder to be severe and unkind, determined by the regression from the more mature superego characteristic of the genital organization. The role of the defenses is undoing and isolation in the obsessional. Although obsessional ideas are conscious, they are disguised and distorted substitutes for the unconscious impulse that is warded off. (Esman, 2001, p. 321)

In other words, the conscious obsession masks the unconscious forbidden thoughts or impulses of the id. For example, an OCD patient with obsessions central to danger, "Someone will break in and murder my family", will have compulsions central to safety, "I can't be sure the door is locked until I lock and

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unlock it exactly 10 times perfectly". However, the underlying unconscious anxiety masked by the obsession may be his or her own aggression or wish to harm others (e.g. his family). A harsh superego discourages even mild, natural aggression or wishes from entering consciousness.

Other obsessions may not be as disguised. Some obsessional material is rather raw. For example, an OCD patient may experience obsessions in the form of violent or sexual imagery that cause anxiety due to the judgment cast by the superego. Compulsions might include a form of ritualistic prayers and/or compulsive mental acts such as counting, repeating words, or inserting particular "pure" thoughts to combat the "evil".

The presence of a punitive superego in early personality development may be a precursor to OCD. "Significant is a dissynchrony between ego development and libidinal development; precocity in the former encourages repression and the development of obsessional defenses" (Esman, 2001, p. 321). The advancement of a particularly harsh superego can stifle libidinal development. The superego is positioned to cast judgment on most libidinal impulses or thoughts working to prevent them from surfacing to consciousness.

Weissman (1954) distinguished between the harsh superego of the obsessive-compulsive neurosis and the more mature superego of the "normal" person. Someone without OCD may have thoughts and feelings of an unpleasant or "impure" nature and experience some discomfort with the content. Such

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thoughts and feelings would be allowed to pass through the stream of consciousness with some regularity. Weissman understands different individuals to experience different levels of discomfort depending on a valence for anxiety. The OCD patient will separate "pure" and "impure" conscious content, excessively expending energy on a judgment process. He or she will employ compulsive rituals to eliminate the non-permissive or "impure" material from consciousness.

In addition to banning certain material from consciousness, omnipotent fantasy plays an important role in the development of OCD. Ferenczi shared Freud's ideas of omnipotent thinking, a tendency for a child to develop a sense of power through "magic thoughts and words" when the external object world is physically or emotionally threatening (Esman, 2001). A regression back to this phase of development could come in the form of OCD in order to fend off a dreaded outcome or particular anxiety by indulging in the fantasy of omnipotent control.

From an object relations perspective, symptoms of OCD may be understood as an effort to cope with intense conflict between the patient's inner world and external reality. The internal object world may contain punitive and dangerous representations of external objects. The internal world is split into "good" and "bad". The bad or threatening parts of this world are fervently warded off by splitting them away, and banishing them into unconsciousness. The

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use of splitting maintains the patient's position as part object related (unable to hold positive and negative attributes of self and others in mind simultaneously). He or she will split off threatening thoughts, images or impulses from his or her stream of consciousness in order to maintain a false but safer, more predictable internal experience. OCD might be understood as the failure for an individual to become whole object related (the ability to hold both good and bad aspects of the self and others in mind simultaneously).

Klein believed that individuals are born with an ego intact (St. Clair, 1996). She postulated that splitting allows for keeping good and bad aspects of the ego separate in order to create a more simplified and manageable internal experience. An infant initially experiences the world as out of control; events simply happen to him/her. Later, if an infant introjects external objects as hostile and aggressive, they become internal threats to the child. Splitting these threats off disperses dangerous feelings, keeping them separate from pleasing feelings. "In effort to defend themselves, infants try by phantasy processes to impose their own inner world on the external world and then reinternalize that world. In essence, the infant is creating his or her own world" (St. Clair, 1996, p. 44).

Failure to eventually meet certain milestones in the development of a more accurate perception of reality can leave an individual prone to pathology later in life. OCD may become a strategy for surviving in an internal object world that is dangerous. Continued splitting off of destructive feelings, thoughts, and images

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is a method to protect against fears of retaliation from the hostile and aggressive internal objects.

Fairbairn rejected Freud's notions of biology and drives, and instead believed that object relations were purely responsible for development (St. Clair, 1996). In this scenario, OCD may be seen as a self-protective measure; symptoms are used to help reinforce repression. In order to be protected from external dangers, a child will internalize the bad objects of the external world in order to gain control of them. This process works to convert the environment into good objects, but leaves the child with the bad objects internalized. The inner bad objects or persecutors are defended against through repression. Depending upon the intensity of this process, psychopathology can result. OCD symptoms can be understood to serve as a method to reduce anxiety by maintaining the expulsion of bad objects from consciousness. Again, intolerable thoughts (obsessions) are driven into unconsciousness with the help of compulsions.

Child abuse, particularly sexual, may increase the probability for the development of OCD symptoms in order to cope with the trauma. "Empirical research has confirmed that sexual and physical trauma plays a significant role in adult psychopathology" (Stein and Stone, 1997, p. 4). Although a direct link of OCD to early childhood trauma is yet to be seen, OCD symptoms are a viable option as a coping mechanism for extreme anxiety.

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A child will likely experience libidinal wishes directed at a parent. When Oedipal wishes result in sexual contact with a parent, the space between the child's fantasy world and reality collapses. The child is left to believe that his or her wishes can have actual effects on him/herself and others. The anxiety caused by the belief that thoughts and wishes have such power can be overwhelming. Obsessive-compulsive symptoms can mitigate some of this anxiety by insuring that negative or harmful wishes remain unconscious, relieving the individual from any sense of responsibility for harm.

Contemporary psychodynamic/psychoanalytic thought on Obsessive-Compulsive Disorder is incorporating more of the recent findings of biopsychology, helping to bring psychodynamic/psychoanalytic concepts more up to date. While there is much left to be understood about the relationship between psychodynamics and brain biology, some recent developments are interesting. "The symptoms of OCD almost always have interpersonal meaning to be addressed. Biologically determined symptoms may serve as the ideal vehicle to express psychodynamically based conflicts" (Gabbard, 2001, p. 218).

One example is an interesting observation found in studies of women who are pregnant or caring for their children, and a possible biological link to the onset or exacerbation of OCD symptoms. This finding may suggest an interplay between biology and analytic concepts (Gabbard, 1994). Implied is a shift in biochemistry in pregnant and new mothers contributing to an exacerbation of

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OCD symptoms. The reasons for this biological phenomenon remain unclear, however a correlation is evident. According to Gabbard (1994), Buttolph and Holland discovered that patients with OCD found an exacerbation of their symptoms to be related to care of their children, pregnancy, or childbirth. Gabbard continued with Neziroglu, Anemone, and Yaryura-Tobias, who conducted a study of 106 female patients suffering from OCD and noted that pregnancy was associated with the onset of OCD symptoms more than any other life event. In fact, 39 percent of those patients with children first experienced symptom onset during pregnancy.

Gabbard (1994) found that his patients with OCD who were young mothers or who were pregnant had increased intensity of the OCD symptoms and a rise in unconscious or barely conscious aggression toward the child. It is reasonable to assume that a mother may have conflicting feelings of love and resentment for her child, and that some mothers may not allow the feelings from the negative side of this conflict to enter consciousness. For example, one OCD patient who was a new mother of a six-month old said that she immediately turned off the television whenever a news story or talk show featured a discussion of child abuse by parents. In the course of psychotherapy, she recognized the extent to which she struggled with overwhelming murderous wishes toward her child. While the form the obsessional thoughts took often suggested danger from the outside would strike down the child, dynamic exploration helped the patient

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understand that the threat she feared really came from within rather than from external sources. Part of this conceptual model is that symptoms, no matter how biologically influenced, nevertheless have meanings, conscious or unconscious, to the patient. "Psychodynamic conflicts frequently appropriate the biochemical forces within the brain and use them as a vehicle of their expression" (Gabbard, 2001, p. 212).

Dynamically speaking, Gabbard believes that a key factor in the development of the disorder is conflictual emotions (1994). Feelings of love and hatred cannot be held in consciousness at the same time in an OCD patient's mind. When this conflict is unbearable, OCD symptoms are a feasible defense option. The obsessive-compulsive individual is typically plagued with intense ambivalence. This confusion is anxiety provoking since the individual can allow only the purest feelings or thoughts into consciousness. The simultaneous presence of love and hate leaves the patient consumed with doubt about the appropriate course of action. The split-off impure material can be pushed out of the OCD patient's stream of consciousness by intensely focusing on a compulsive activity or using defenses of isolation, reaction formation, intellectualization, or undoing. Aggression, hostility, and sexual impulses are a few examples of emotional material that would likely be restrained from consciousness.

To summarize, some of the psychodynamic/psychoanalytic perspectives for the causes of OCD emphasize the responsibility of an overly critical superego.

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Others view OCD symptoms as a strategy to manage intolerable feelings stemming from an environment perceived to be threatening. Contemporary contributions are scarce, but when recent findings in biopsychology are incorporated with dynamic formulations, a new frontier in psychiatric research is identified.

Essential concepts developed by three schools of thought for the causes of OCD have been presented. Biopsychology has made vital advancements towards understanding the role that abnormal brain activity plays in Obsessive-Compulsive Disorder. Cognitive perspectives conceptualize OCD in terms of schemas and thought distortions that leave an individual prone to developing an over-inflated sense of responsibility for negative outcomes. Psychodynamic/psychoanalytic perspectives on the causes of OCD view the disorder as a way to manage conflict and anxiety. OCD symptoms render particular thoughts and feelings to unconsciousness in order to reduce anxiety. Future analytic contributions on the subject of OCD are needed. However, the various offerings to an understanding of the causes of OCD do not necessarily oppose each other and can work in harmony. OCD is now viewed as "[a]t the least, multiply determined, with components of neurobiology, learning and conditioning and conflictual elements synergistically involved" (Esman, 2001, p. 320).

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Treatment

Approximately 90% of sufferers who seek treatment are successful in their quest for relief; however, less than 20% of sufferers of OCD seek treatment (Kolata, 1995). This reluctance to get help is probably in part due to the shame or embarrassment brought by their symptoms. Because of this tendency to keep the disorder a secret, there is often a delay of five to ten years before patients seek help (Jenike, 2001). Many may be confused about the benefits of treatment and fear losing the rituals that fill a particular purpose. The OCD sufferer finds it nearly impossible to control his or her thoughts and actions, and also cannot explain why they persist.

When patients seek help, they are often frightened and confused by their obsessive-compulsive symptoms and left to choose a form of therapy with little information as to what would best suit their needs. Today's psychotherapists utilize a range of treatments for OCD, some with promising results. But patients and therapists alike may find it frustratingly difficult to settle on a recommended treatment model. The literature depicts different perspectives on OCD between the biopsychologists, cognitive behavioral therapists, and the psychodynamic/psychoanalytic therapists. A psychotherapist may be the first person an obsessive-compulsive talks to, needing help and information about options for treatment. This section is aimed to provide psychotherapists with an introduction to some of the more prominent treatment approaches for OCD.

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Modalities of treatment covered here will include medication, cognitive behavioral, and psychodynamic/psychoanalytic therapies.

Medication. According to Osborne (1998), a combination of psychotherapy and proper medication is usually most effective in the treatment of Obsessive-Compulsive Disorder. Fortunately, new expectations in treatment prevail over what was once considered to be a disorder difficult to treat. Osborne suggests that combinations of psychotherapy and medications have been successful in treating over 90% of individuals with OCD.

The medications most useful for OCD are the selective serotonin reuptake inhibitors (SSRIs) (Osborne, 1998). Some of the more commonly prescribed drug name brands include Prozac, Paxil, Zoloft, Anafranil, Luvox, Celexa, and Lexapro. These SSRIs are associated with the reduction of anxiety, the driving force behind most symptoms. SSRIs take their name from a unique biochemical action, their ability to influence serotonin, a certain brain chemical that has been found to play a key role in the production of obsessions and compulsions. Serotonin is a neurotransmitter; it serves as a messenger between brain cells and is currently understood to play a part in happiness and a sense of comfort and safety. Molecules of serotonin are released from one brain nerve cell to another. Some serotonin is reabsorbed back into the first nerve cell to be used again.

The SSRIs specifically interfere with the re-absorption, or reuptake of serotonin. As a result, more serotonin is carried across nerve cells. Research into

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how they do so has yielded two outstanding findings. First, SSRIs are extremely selective in their effect; they have little impact on other neurotransmitters in the brain, of which over a hundred have been identified to date. Second, in treatment of OCD, the SSRI medications have their major therapeutic impact in one small area of the brain. Brain imaging techniques able to show the brain at work, reveal that OCD is associated with a hyperactive circuit of nerve cells running from the basal ganglia to the orbital frontal area of the brain. SSRI medications decrease the firing of nerve impulses in this circuit. What patients report is that the SSRIs allow them to let go of obsessions more easily, and to more readily resist the urge to perform compulsions.

Osborne warned that there are a few general principles to keep in mind once the decision to use medication has been made. First, medication is generally not a complete cure. Studies such as the Clomipramine Collaborative Study Group (Osborne, 1998) demonstrated that SSRIs usually bring about a drop in OCD symptoms to the 30 percent range of what they were. This would mean that someone who engaged in compulsive rituals for about three hours per day could reduce this behavior to one hour.

Secondly, the adjustment of medication is often a process of trial and error. One SSRI medication can work when another does not, and there is no clear way to predict effectiveness. Adding a second medication, an augmenting agent, to an SSRI can often kick-start a treatment that at first seemed ineffective.

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Thirdly, variations in the dosage of medication are often required to treat OCD effectively. This is due to a number factors, including how well a drug is absorbed into the body, how efficiently it is metabolized by the liver, how quickly it passes through blood-brain barrier, and how strongly it affects serotonin. There are many differences in effective dosages among patients using standard antidepressants, including SSRIs.

SSRIs are subtle in terms of their subjective effect. A patient may be tempted to cease the medication regimen once he or she begins to feel cured, which is likely to spur the return of symptoms. However, Osborne (1998) stated that 30% of OCD patients do not respond well to medication and may need to discontinue pharmacological treatment as a result.

To date, the most effective medication for the treatment of Obsessive-Compulsive Disorder is serotonin reuptake inhibitors. The process of finding the best SSRI and appropriate dosage varies from patient to patient. However, medication alone is generally not adequate for the treatment of OCD.

Cognitive Behavioral Approaches. Cognitive Behavioral treatment is a combination of two separate treatment modalities, cognitive intervention and behavioral modification. Cognitive therapy is the application of cognitive theory, which addresses the way in which people interpret events, or how they make their own realities. Personal theories of how the world works (schemas) are developed which in turn filter all incoming stimuli and organize the ways people take

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information in. Individuals soon learn to expect particular outcomes based on their previous experiences of given stimuli. As discussed earlier, maladaptive schemas, and the negative automatic thoughts and erroneous beliefs that support them, are conceptualized as primary causes for OCD. Cognitive therapy focuses on the understanding and restructuring of schemas, challenging negative automatic thoughts, and correcting erroneous beliefs.

Schemas can be understood as similar to transference, and are central to cognitive theory. Just as transference can be attributed to unconscious process, schemas are also regarded as unconscious. A cognitive therapist can help the OCD patient bring maladaptive schemas into consciousness by focusing on the therapist/patient relationship, much like a psychodynamic therapist would work with transference. For example, an OCD patient may believe that he will be personally rejected and thrown out of treatment if he admits to feelings of greed or aggression. The therapist can help the patient to see his fears as a maladaptive schema at work and provide a different experience in the therapeutic relationship.

In order to educate the obsessive-compulsive patient about his or her negative automatic thoughts and erroneous beliefs, they first must be identified in treatment. Cognitive behavioral therapists sometimes help the patient to categorize these thought distortions. A few examples would include: all or nothing thinking, overgeneralization, jumping to conclusions, and "I should or I shouldn't" thoughts directed at the self. Once these thought distortions are

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discovered and identified in the client's habitual, automatic thinking, it then becomes possible to modify the thoughts by substituting rational, realistic thoughts for the distorted ones (Fadiman and Frager, 1994).

Thought records are sometimes used to facilitate the process of identifying problematic thoughts and beliefs that may otherwise go unnoticed by the patient. Thought records raise awareness as well as aid the therapist and patient in their work together to bring about change. In order to do this, the therapist and patient may talk through a scenario that the patient is having difficulty with, identifying problematic thought patterns along the way. For example, if a patient is struggling with excessive hand washing, the therapist and patient write down feelings, thoughts, and beliefs associated with the compulsion. Together, they may discover that the anxiety the patient is feeling stems from beliefs that he will become contaminated with germs, that he is filthy, the germs may kill him, or that he may contaminate others he comes in contact with. Once the automatic thoughts and beliefs are identified, they can be critically evaluated and challenged. How much does the patient believe these thoughts to be true? What is the evidence that they are true or false? What is the worst that could happen? Could the patient live through it? What is the most realistic outcome? What is the effect of the thought? What should be done about it? If a friend had the same thoughts or beliefs, what would the patient say to him/her? Together, the patient and therapist work to develop alternative, more adaptive responses. For the

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obsessive-compulsive, this process of challenging and changing thought patterns may be slow and tedious.

The patient and therapist can work collaboratively on various scenarios. Eventually, a thought record may require that the patient do some "homework," recording negative thoughts and erroneous beliefs as they occur, then bringing the record into therapy for help.

Unlike cognitive theory, behavioral theory does not acknowledge an unconscious. Behavioral modification simply focuses on changing the pathological behavior of an individual. Primary methods are exposure and response prevention techniques. An OCD patient would be aided in refraining from engaging in compulsions. First, the patient would be exposed to an anxiety-provoking trigger, then told to refrain from her typical response (i.e. compulsion). For example, if she spends 20 minutes washing her hands for fear of dirt or germs, she would be asked to touch something "dirty". Then she would be asked to refrain from washing and to tolerate the anxiety. The strictness of response prevention may vary. If refraining all washing were too intolerable, she would be given assignments to reduce her washing in increments. She might time herself and begin to limit the washing to perhaps 15 minutes, becoming conditioned to tolerate the entailing anxiety more slowly. Increments for reduction would be adjusted according to the patient's ability to tolerate anxiety until the compulsive behavior is finally eliminated.

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Behavioral interventions can help an OCD patient to feel helped fairly quickly with some sense of control over symptoms. “Even when they are extremely distressed, patients often understand and can carry out behavioral changes, whereas subtle cognitive distinctions and changes may be difficult to comprehend at first” (Persons, 1989, p. 58). In fact behavior therapy and medication are often the treatments of choice for OCD, and are empirically supported as most efficacious (Leib, 2001; Gabbard, 2001). “Yet behavior modification and pharmacotherapy both yield symptomatic improvement in little more than half of treated patients, and relapse is frequent after discontinuation of treatment” (Leib, 2001, p.223).

Behavioral modification in concert with cognitive therapy can often augment treatment. This is particularly true for the treatment of Obsessive-Compulsive Disorder. OCD is an ailment consisting of both cognitive and behavioral factors. Obsessions can be addressed with cognitive interventions, while compulsions can often be reduced through behavioral modification.

For example, Kolata (1995) reviewed the work of Lec Pollard, who directs the Anxiety Disorders Center at the Saint Louis Behavioral Medicine Institute. Pollard states that cognitive behavioral therapy for OCD has two stages. First, patients are educated and helped to understand that they are exaggerating the dangers in their environment. He addresses and challenges the erroneous beliefs that trigger OCD symptoms. Then patients are taught to expose themselves

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deliberately to the things they are afraid of, and to refrain from their rituals. These tasks can be done incrementally, working towards cessation of symptoms.

Levenkron (1991) shares helpful guidelines for the cognitive behavioral therapist to incorporate into treatment when working with an OCD patient. He encourages the therapist to be concrete, providing clarity about treatment immediately, and to explain what treatment will include and what the client can expect. Facilitating attachment with the client will increase transference in the treatment process. Allowing the patient to become dependent upon the therapist with predetermined limits can facilitate an attachment, and places emphasis on the therapeutic relationship.

Cognitive behavioral therapy in various forms has been used in some studies that measure the effect of psychotherapy on OCD by use of brain scans. Results have shown that psychotherapy can have an effect by influencing change in neurological pathways of the brain. PET scans of brain activity after therapy show markedly decreased activity in the "are you sure the stove is off?" circular trap based on the results of a UCLA study by Jeffrey Schwartz (Begley and Biddle, 1996). Schwartz was quoted, "We used to think that once you got past your twenties, there wasn't a lot you could do to change your brain, but this is strong evidence that the brain is more pliable than previously thought" (Glausiusz, 1996, p. 36).

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Schwartz and his researchers used PET scans to examine 18 patients, ranging in age from 25-51, before and after ten weeks of therapy without medication. Schwartz's team focused on the four areas known to be involved with OCD. The orbital cortex, the caudate nucleus, the cingulated gyrus, and the thalamus.

Normally, once a person perceives there is no real cause for anxiety, high level thought processes override the distress signals and cause the caudate to switch them off. But in OCD, this doesn't happen. With PET scans, Schwartz and his colleagues found that before treatment, all four of the regions they studied metabolized glucose at very high and correlated rates, as if they were interlocked.

This phenomena disappeared in 12 patients who responded positively to a cognitive behavioral treatment utilizing re-labeling and re-focusing techniques. Patients were asked to re-label their compulsions as an urge instead of necessity, then to re-focus on a constructive activity. The absorption of glucose dropped, and energy use among the four areas became less tightly linked; each area worked more independently. When the process was successful, PET scans showed a reduction in brain activity around obsessive thought cycles after one hour of weekly therapy sessions for eight to 12 weeks, combined with practice in re-labeling and re-focusing that was done at home. The twelve learned to tolerate the fearful messages his/her brain received in OCD and changed his/her responses. Schwartz's patients first re-labeled their compulsions. Feeling the need to wash

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their hands for the umpteenth time that day, they told themselves, "I am having a compulsive urge." They focused on some constructive activity; gardening, playing an instrument, or knitting, for 15 minutes. As another part of the brain is engaged, the obsessive thought patterns urging the patient to wash his or her hands become diminished.

According to Schwartz (1999), controlled studies of cognitive-behavioral therapy techniques utilizing the active refocusing of attention away from the intrusive phenomena of OCD and onto adaptive alternative activities have demonstrated significant improvements in clinical symptoms. His work suggests that systematic changes in the pathological brain circuitry are associated with treatment.

> The ability of OCD patients to clearly describe their symptoms also allows the investigation of how their conscious experiences change with treatment. Since there are now very effective means of alleviating OCD symptoms through the utilization of both pharmacological and psychological interventions, as well as significant evidence that each of these treatments independently cause similar changes in patterns of cerebral glucose metabolism in patients who respond to them, it has become possible to track how post-treatment changes in the cerebral metabolism of functionally

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> well characterized brain circuits relate to changes in the internal conscious experience of clearly defined neuropsychiatric symptoms. (Schwartz, 1999, p. 116)

With the help of cognitive behavioral psychotherapy, it is possible for an individual to alter his or her own brain activity in the direction of greater mental health. Schwartz's findings are promising to the recovery potential for individuals with OCD.

Challenging and reframing old schemas and maladaptive thoughts and beliefs, as well as developing behavioral interventions can diminish OCD symptoms. Abnormal brain chemistry, as evidenced by brain imagery techniques, can be corrected through the use of cognitive behavioral psychotherapy techniques.

Case Vignette. The following is a summary of a case borrowed from Dumont (1996). The patient presented illustrates the symptoms of an extreme case of OCD. Dumont successfully treated this patient under a cognitive behavioral model.

Gracie was a 53-year-old woman who had suffered from OCD for as long as she could remember. She spent eight hours a day bathing, was terrified of dust, dirt, and germs. As a child, she recalled that using the school bathroom was nearly impossible. She would not allow herself to touch the bathroom door for

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fear of germs. She would wait by the door until someone else came to open it, then she would slip in without having to touch it. She opened and closed the door to the stall with her foot, and used the toilet balancing on one foot while she held the door closed with the other. Upon leaving the stall, she took a wad of toilet paper with her to turn the faucet handle at the sink. After she washed her hands, she would leave the water running and return to a stall to get more toilet paper to turn the water off (she could not use the same wad of paper because it had been contaminated by her prior dirty hands).

Gracie's symptoms increased in severity as she aged. Once she entered college, she was unable to use the dormitory bathroom until she could spend several hours scrubbing the walls, the sinks, and the bathtubs. She would wait until the other dorm residents were in bed before she started her scrubbing and bathing rituals. Some nights she wouldn't get to bed until four or five o'clock in the morning. She was afraid of shoes because they touched the dirty pavement. No one could come into her room wearing shoes. In the first two months of college, three roommates filed protests and refused to room with her.

Gracie's life at college became impossible, and she eventually dropped out and moved back home to live with her family. Her OCD continued to worsen. She limited herself to her bedroom and bathroom. Her brothers grew up and eventually moved out. Her father passed away, and her mother became ill.

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Gracie was afraid of becoming contaminated by her mother's illness and refused to nurse her. A live-in nurse was able to convince Gracie to get treatment.

Dumont had to come to Gracie's home for therapy sessions. She was not allowed into Gracie's room due to Gracie's fear of germs, so therapy continued with a closed door between the two women. Progress was painstakingly slow; after five months, Gracie's brother Charlie was able to enter the room, yet Dumont was still not permitted. Dumont and Charlie began to work together. Charlie began doing exposure assignments with Gracie.

Dumont thought that medication was a necessity for Gracie, but Gracie would not allow any doctor to examine her in order to prescribe. She was absolutely resistant to the prospect of being visited by an M.D. This was a significant hindrance to Gracie's progress as a result. Her obsessions and compulsions were heavily obstructing the therapeutic process. Dumont was forced to continue without the assistance of medication.

After six months of therapy, Dumont saw Gracie for the first time. She stood at the open door of her bedroom while Dumont stood at the foot of the stairs. Soon, Gracie, Charlie, and Dumont were meeting in the living room. After Dumont touched the sidewalk outside, Gracie would touch her hands and see that nothing bad happened to her. Next, Dumont touched her dirty car and touched Gracie. Again, nothing bad happened to her.

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Each time they did something new, Gracie experienced great distress. She was sure that she would die or go crazy if she couldn't immediately wash or perform rituals. Charlie and Dumont reminded her that she had the same feeling on numerous occasions, but never died or went crazy.

When Gracie went silent and became distant, it was a sign that she was saying litanies to herself, hence removing herself from the situation. During the performance of one of her silent litanies, Dumont would ask what the thought was. "Gracie, what is the thought? Let's cause and effect the thought. How can thinking about something dirty make you sick? If we think about a million dollars, will that make us rich?" Gracie was trying to exorcise impure thoughts from her mind with the use of litanies. If the thoughts were not exorcised, the belief was that something horrible would happen to Gracie or to someone.

Dumont eventually made it into Gracie's bedroom. Gracie and Dumont progressed to working in the bathroom together to reduce her washing time. First Dumont demonstrated how she washed her own hands while Gracie counted to see how many seconds it took. Then Gracie tried it while her therapist counted. With her therapist helping to keep a pace, Gracie was eventually able to wash her hands in 30 seconds, down from her previous speed of 20 minutes.

After a year, Gracie was able to venture out of the house. After two and one half years, Gracie ceased therapy. She was able to function comfortably in public, and decided to go back to school to earn her degree. She had contacted an

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OCD group and was offering hope and help on the telephone to individuals with the disorder.

Medication might have been helpful for Gracie if she had been able to tolerate a medical exam. In this case, she progressed through therapy alone. Dumont had to make some adjustments to her normal routine as a cognitive behavioral therapist due to Gracie's extreme set of OCD symptoms. In this case Dumont had to treat her patient in the patient's home and had to use Charlie as a bridge. Gracie was helped by behavioral modification exercises of exposure to the dirt and germs that she feared and learned to limit her compulsive behaviors. With Dumont's help, she was able to cognitively restructure her fears of contamination and impending dangers.

Psychodynamic/Psychoanalytic Approaches. With few exceptions, the majority of the analytic material does not distinguish OCD from OCPD. It is difficult to glean an insightful analytic perspective on OCD due to the lack of contemporary literature specifically addressing this disorder. However, there is extensive literature addressing the obsessive-compulsive character. Assuming for the moment that OCD and OCPD are related, the analytic literature has a significant contribution to make.

The psychodynamic/psychoanalytic treatment model assumes that unconscious anxiety is mitigated through obsessive-compulsive symptoms. The therapist strives to understand dynamic meaning for the neurosis by surfacing

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unconscious anxiety. This method explores the unconscious anxiety and conflict underlying the obsessions and compulsions. It is assumed that once the unconscious anxieties are understood and conflicts are resolved, symptoms are defunct. Psychoanalysis would view OCD as a defensive system which is a result of an underlying condition, not a disease itself.

The analytic therapist attempts to understand the underlying dynamics of the patient with OCD, rather than focusing on specific techniques. Unlike the cognitive literature which spells out specific steps, the psychoanalytic approach has everything to do with understanding the patient.

As quoted in Fadiman and Frager, (1994), Freud defines psychoanalysis as follows:

> Psychoanalysis is the name (1) of a procedure for the investigation of mental processes which are almost inaccessible in any other way, (2) of a method (based upon investigation) for the treatment of neurotic disorders and (3) of a collection of psychological information obtained along those lines, which is gradually being accumulated into a new scientific discipline. (p. 19)

Psychoanalysis aims to reveal and understand unconscious thoughts and feelings that are assumed to be played or acted out in symptomology. "The

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analysis aims at laying bare the complexes which have been repressed as a result of the painful feelings associated with them, and which produce signs of resistance when there is an attempt to bring them into consciousness" (Freud, 1906, p. 109). One of the tasks of psychoanalysis, is to "lift the veil of amnesia which shrouds the earliest years of childhood and to bring the expressions of infantile sexual life which are hidden behind it into conscious memory" (Freud, 1933, p. 28). According to Freud, the goal of psychoanalysis is to free the patient from the inhibitions of the unconscious so that the ego can establish new levels of satisfaction. The resolution of anxieties rooted in early childhood frees blocked or displaced energy for more realistic and complete gratification of one's needs (Fadiman & Frager, 1994).

Freud originally thought that OCD was a result of internal conflict. Based on his observations of the "Rat Man" case, he suggested that libidinal instincts such as sadistic impulses, and their defenses, such as withdrawal of affect, are involved in OCD. He argued for the need to translate the meaning of symptoms, and stated that "[p]atients themselves do not know the wording of their own obsessional ideas", "[t]he obsessional idea exhibits... in its distortion from its original wording, traces of the primary defensive struggle" (Freud quoted by Stein & Stone, 1997, p. 4). Freud believed that obsessive-compulsive symptoms always had an historical or symbolic meaning to be interpreted (Stein & Stone, 1997).

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Unconscious anxiety stemming from wishes, aggression, and an array of forbidden affects can be uncovered and processed consciously. For example, an individual may be consumed by obsessions consisting of images of something harmful occurring to a loved one. The compulsions activated to counter anxiety caused by these images would likely consist of activities central to safety, such as checking locks and stoves, or saying prayers repetitively to ask for God's protection. He or she would believe that something tragic would happen to a loved one if the compulsions were not performed. What may be left to discover in treatment would be the forbidden aggressive wishes, possibly that a particular loved one *is* harmed.

Kleinian theory, like others, suggests that psychological danger comes from within (St. Clair, 1996). Destructive feelings a child has for different objects stir up fears of retaliation. Emphasis in treatment is placed on inner objects and phantasies (ideas, meanings and expectations attached to objects). The task of therapy is to relieve and understand anxiety, and to modify the harshness of some of the internalized persecuting objects. This process is achieved by analyzing and interpreting the transference (St. Clair, 1996).

Transference is the process of the patient applying feelings and phantasies of past relationships onto the therapist. Analysis of transference enables the patient and therapist to explore early relationships and feelings attached to them and allows for new versions of the phantasies, fears, and feelings that were

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involved in past relational experiences. "Therapeutic change comes about through analysis of the transference and by connecting current feelings and attitudes with the earliest object relations" (St. Clair, 1996, p. 50). The psychotherapist can help the patient reshape the objects that represent threat.

Fairbairn emphasized that therapy must help the patient to make direct and full contact with others since disturbances are derived from problematic relationships with others. The therapeutic goal is to release bad objects from the unconscious and share them with another individual. In other words, some internalized objects are repressed because they were once intolerable. Bringing them into consciousness to be processed in treatment can help reduce their threat. "Only when these internalized bad objects are released from the unconscious can their cathexis or emotional power be dissolved" (St. Clair, 1996, p. 66).

A therapist can facilitate this process by becoming a good object; that is creating a safe, supportive, and comfortable therapeutic environment. The therapist has to be careful not to side with the patient's superego, as guilt will increase resistance. If the patients inhibition brought about by guilt decreases, and if the therapist is not perceived as judgmental, the patient may feel safe enough to bring some of the internalized bad objects into consciousness.

From a different perspective, Salzman states, "The essential task in the therapy of the obsessive-compulsive disorders is that of conveying insight and initiating learning and change without getting caught in the obsessional tug-of-

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war" (Salzman, 1968, p. 179). According to him, an OCD patient is likely to steer the therapist into obsessive, intellectual, detail-oriented debates. Most of these obsessional patterns arise from a feeling of powerlessness, not from hostility. Psychotherapy can quickly become a struggle over power and control instead of a collaborative venture. Salzman moves away from the notion of neutrality and encourages therapists to actively participate in the treatment, combine firmness with flexibility, be aware of countertransference feelings, and emphasize the here and now (Stein & Stone, 1997).

Many OCD patients are masterful at controlling the therapeutic hour by directing attention away from uncomfortable affect. The meaning of this behavior by the patient can be analyzed in order to work through resistance to the therapy. "Many OCD patients seem to hang onto their symptoms, tenaciously resisting treatment efforts." (Gabbard, 1994, p. 270). Additionally, a supportive style with clear limits and boundaries are important on the therapist's part so not to feed the patient's symptomatic sense of omnipotence. The belief that he or she can control the therapist needs to be contested and eventually analyzed.

It seems clear that from any major dynamic or analytic perspective, a key component of treatment includes a focus on the relationship between the patient and therapist. The therapist will likely notice that a patient with OCD has little material to share that is openly hostile, sexual, or aggressive in nature. More often than not, such feelings will be hidden from consciousness. It is likely that

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an OCD patient will be quite resistant to venturing into such emotional territory. Furthermore, the therapist would likely become aware of such feelings within him/herself during the therapeutic hour as a result of projections coming from the patient. Clearly, the transference and countertransference are key aspects of an analysis that attempts to understand the patient's unconscious material.

However, according to Gabbard, just as it is imperative to focus on unconscious process, it is also important not to force the OCD patient into premature awareness of his or her own unconscious feelings. Given the investment that an OCD patient must place in maintaining his or her symptoms, it is reasonable to believe that what the symptoms work to defend against is significantly threatening. The structure of the OCD symptoms may have multi-purpose functions. An important question would be: "Where does the patient's symptomatology lie on the neurotic-psychotic continuum?" Gabbard warns the therapist treating a patient with OCD:

> The symptoms themselves may fend off psychotic disintegration in some patients, thereby performing a highly useful function in terms of psychological homeostasis. Because the symptoms of OCD may accompany any level of underlying personality or ego organization, a careful psychodynamic evaluation should also focus on the

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> function of the symptoms in the patient's overall intrapsychic structure. (Gabbard, 1994, p. 270)

In other words, for some patients approaching the psychotic side of the continuum, it may be possible that OCD also serves to maintain psychological structure that would otherwise feel prone to disintegration. A psychotherapist is well advised to keep in mind a patient's need for symptoms at a given time.

Glen Gabbard, M.D. is one of few contemporary analytic authors emphasizing a perspective that incorporates the latest discoveries in biopsychology while acknowledging valuable contributions from the cognitive behavioral arena. Although there is little empirical evidence that psychodynamic/psychoanalytic treatment is beneficial for OCD, he maintains that it fills an important role in treatment. "Despite the impressive research in the neurosciences about the biological underpinnings of OCD, the psychoanalytically informed therapist still has much to contribute to a comprehensive treatment plan for such patients" (Gabbard, 2001, p. 211).

Gabbard asserts that many patients with OCD have characterlogical complications that make them resistant to treatment. Dynamic therapy is often well suited to address these complications.

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> Another cogent reason to incorporate psychodynamic strategies with OCD patients is the fact that many have significant characterlogical issues that serve as powerful resistances to forms of treatment such as behavior therapy or pharmacotherapy. In fact, Baer et al. (1990) found that the presence of schizotypal, borderline, and avoidant personality disorders predicted poor treatment outcome in patients with OCD treated by Clomipramine. (Gabbard 2001, p. 216)

OCD can arise from a complex and troubled character organization, complicating treatment. "Moreover, even when patients fall short of meeting DSM-IV criteria for a personality disorder, they still may have prominent characterlogical features that interfere with the implementation of a comprehensive treatment program" (Gabbard 2001, p. 216).

Psychoanalytic/psychodynamic treatment addresses the difficulty in interpersonal relationships the OCD patient will likely encounter. Gabbard states that sometimes OCD plays a role where symptoms are not always only patient centered, but often extend into controlling families and other relationships. "Despite the refractory nature of many obsessive-compulsive symptoms, psychodynamic therapy may considerably improve the interpersonal functioning

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of OCD patients" (Gabbard, 1994, p. 270). As with any disorder, OCD is not an ailment that typically affects the individual in isolation. In its "purest" form, OCD symptoms may bring about minimal interpersonal complications when the patient is working to keep symptoms secret. But if not, those close to the OCD patient may feel pressure to appease him/her to help control anxiety in the patient and in themselves. Family and friends may often have difficulty understanding OCD and why individuals with the disorder are compelled to behave in such peculiar ways. Other lives are often adversely affected as spouses may feel confused and distant, friends and/or family members may be imposed upon or asked to do seemingly bizarre things in order to enable the obsessive-compulsive behavior in someone they care about. In many cases, family therapy may be necessary.

Many OCD patients may gain added therapeutic benefit, support, and solace through group therapy. According to Gabbard (1994), psychoanalytic oriented group therapy may provide additional help in relief of OCD symptoms. Throughout the course of group therapy, members can express their forbidden thoughts, fantasies, and feelings openly before other members. With no disastrous ramifications from this disclosure, the members can slowly learn to let go of the anxiety that accompanies these feelings. In addition to witnessing the group's survival after exposure of what the OCD patient may deem forbidden, he or she may benefit from the added support afforded by a group. The group

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experience can allow one to feel understood and related to others while helping to decrease feelings of isolation with the disorder.

The poverty of contemporary psychoanalytic literature on the subject of OCD leaves the field of psychology in need of further research and development. Most classic theories address OCD from the perspective of character. The psychodynamic/psychoanalytic process works to uncover unconscious anxiety, understand its meaning, and aid the patient in tolerating it more comfortably in consciousness. Gabbard is pioneering an effort to understand OCD analytically in a more advanced and updated context. Blending psychoanalytic theories with the new contributions from biopsychology is a direction that may allow for future insight to treatment approaches for OCD.

Case Vignette. The following is a case vignette from my own clinical work at a psychoanalytic clinic during my training. Details in this case were changed to protect confidentiality.

Ron was a 31 year-old first generation Italian-American man who came to treatment for OCD and expressed symptoms of depression and general anxiety. He had been previously prescribed Celexa, an SSRI, yet ceased taking the medication on his own, claiming that it made him gain weight and that he did not "feel like himself". He complained of feelings of emptiness and loneliness. He described his anxiety as near panic at times, yet he was unable to understand why. Ron experienced obsessive and compulsive symptoms that included checking

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door and window locks for security. He checked the stove, furnace, and water heater for gaseous odors. He also complained of his overly consuming fears of being assaulted and did not know where his ideas came from.

Ron was neglected as a child. His parents divorced when he was 10 years old; he lived off and on with each. His father was described as quite narcissistic and often cruel. He had remarried (unsuccessfully) since the divorce and was no longer interested in being a full-time father. He spent long hours at work and drank heavily. Ron's mother was remarried to a man who "did not want her kids around" and resented Ron's presence in their house. She made efforts to spend time with Ron outside of the home. Needless to say, Ron felt quite rejected. His aunt ultimately raised him, representing some stability as he was passed back and forth between parents. He remembered feeling great resentment towards his father as a result of his neglectfulness and selfishness. Ironically, his father developed terminal cancer when Ron was 30 years old. Ron found himself compelled to care for his ill father. This sense of duty to care for him was probably in effort to undo Ron's guilt stemming from some gratification for his father's predicament, as well as any other unconscious hate and aggression directed at his father.

When Ron first appeared in my office, I found him to be polite, articulate, attractive, and well dressed. Yet in session, he frequently complained of feeling unattractive and unlikable. He shared his feelings of loneliness and a longing for

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a satisfying romantic relationship. He said that he had little self-confidence and could not imagine expressing interest in or pursuing a woman due to his fear of rejection. There was an incongruence with his outward presentation and what he spoke of. I was puzzled by his claims of being unable to find a woman who would be interested in him. His sexuality and aggression were curiously absent.

Another major theme was his childhood and how horrific his experience of growing up was. He consistently expressed his story with great despair, portraying himself as a victim. He almost never showed signs of resentment or hostility. In fact, he often joked, smiled, and tried to "entertain" me in session with his humor.

My countertransference was quite strong in a number of respects. First, I usually became quite angry when I heard details of his childhood. How could his parents be so awful? I was experiencing Ron's anger for him. He believed that his own experience of aggression and hostility would make him a "nasty" person. Second, I was quite frustrated by his bind, in that Ron was "forced" into a position to care for his ill father who had been so neglectful of him. Ron insisted that he must, since his father was quite sick and helpless. I was filled with awareness of the irony and resentment that would have left Ron feeling selfish for wanting his own life. And finally, in spite of Ron's complaints of fearing physical attack, I did not feel afraid for him when he shared his paranoid ideations.

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I hypothesized that Ron held unresolved hostility and resentment for his mother and father. He was unable to tolerate his feelings of aggression, hostility, and selfishness due to guilt. After his father developed cancer, Ron defended against these feelings with a reaction formation. As a result, he instead consciously felt fear, pity, and a sense of duty for his father's well-being. His OCD symptoms involved fantasies of harm or impending danger to himself, and invasion to the home he and his father shared. His compulsions of checking and maintaining unrealistic levels of safety were a reflection of his own unconscious wishes to be the aggressor.

I referred Ron back to his treating psychiatrist for a medication evaluation and utilized a psychodynamic approach. Ron remained ambivalent about medication and eventually began to experience some relief from his anxiety without it. I interpreted transference (such as his feelings of being critically judged by me) and helped to make him conscious of his unpleasant feelings, and validated his need to feel them. I was acutely aware of my countertransference, cuing me into some of his unconscious ideas and feelings. Our work was a slow and gentle process, as he was quite resistant to allowing these "dirty" feelings to prevail. Ron who had been previously concerned with being likeable, funny, and entertaining in session began to express some of the less pleasant parts of himself, such as aggression and hostility.

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Ron became more tolerant of his feelings that were once impermissible. He complained from time to time regarding an increase in anxiety. I viewed this as progress as he began to expose himself to uncomfortable thoughts and feelings. I noticed an increase in his assertiveness and directness with me in session. He gradually allowed more of his "ugly" parts to surface while I continued to provide support and validation. By the end of nine months, his symptoms were almost completely alleviated.

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Discussion

A review of current literature on biopsychological, cognitive behavioral, and psychodynamic/psychoanalytic theories for the etiology and treatments for OCD raises several issues important to the therapist treating OCD patients. Given these issues, the psychodynamically oriented therapist may find himself/herself confused as how to proceed with an OCD patient. The analytic literature has provided little help in the effort of updating treatment approaches. However, it is still possible for the creative dynamic therapist to forge an appropriate treatment for the OCD patient, using a multimodal approach. An extensive case example will be provided to illustrate such creative efforts of an analytic therapist.

The first issue revealed by a review of the literature is that the fields of biopsychology, cognitive behavioral psychology, and psychodynamic/ psychoanalytic psychology each make compelling arguments for its theories. Unfortunately they are all presented in a fashion leaving them disjointed from one another. A well-read therapist from any orientation will find useful information from all three schools of thought, but will be left to choose pieces of information he or she has gathered, and then apply them accordingly. The dynamic therapist may be at a disadvantage here due to the fact that the analytic school of thought is the only one of the three without its own strong body of literature addressing OCD as an Axis I disorder.

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The second issue is that analytic contributions are not only scarce, but are mostly outdated. Currently, there are very few authors contributing to the analytic perspective for the understanding and treatment of OCD while major advances have been made in the biopsychology and cognitive behavioral disciplines. In her 1966 paper "Obsessional Neurosis," Anna Freud remained optimistic that the general framework of psychoanalysis is correct for the treatment of obsessive-compulsive neurosis. She acknowledged psychoanalytic limitations, but was confident that understanding of the disorder would progress. Unfortunately, such progress has not come to fruition. "Since the 1965 Congress of the International Psychoanalytical Association... no systematic discussion of the topic has been published in the psychoanalytic literature, nor has the American Psychoanalytic Association devoted a panel to the subject" (Esman, 2001, p. 319). Considering the support for behavioral intervention as an effective treatment choice for OCD in empirical research, it might appear that psychodynamic/psychoanalytic treatment is contraindicated.

The third issue is that the analytic literature fails to adequately address OCD as separate from a manifestation of an obsessional character. As discussed earlier, OCD and OCPD have strong similarities and are both found within a particular character constellation, but the relationship between OCD and OCPD is still quite controversial. Significant research is needed to clarify important differences and similarities.

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Finally, the differences in efficacy between cognitive therapy and dynamic/analytic therapy for OCD remain to be seen. Behavioral modification combined with medication has been empirically supported as an effective combination for treatment in relieving OCD symptoms. These findings are questionable as behavioral treatment is fairly easy to research as compared to dynamic treatment. Behavioral treatment is effective in little more than half of patients treated, and relapse is frequent after discontinuation of therapy. But when behavioral treatment is combined with medication and insight-oriented therapy, a more comprehensive treatment can be provided.

Cognitive therapy is naturally paired with behavioral modification (CBT) while it is not commonplace to combine dynamic/analytic therapy with behavioral modification. Both cognitive and dynamic/analytic therapies work to address and make meaning of unconscious process, but they use different tools and terminology. What might be more effective, cognitive behavioral therapy or dynamic/analytic therapy with behavioral interventions? A comparison between the two approaches would be complex. What criteria would one use to differentiate the two? An entire thesis could be developed to address these questions and are beyond the scope of this paper.

Despite all of the above complications, the psychodynamic/psychoanalytic therapist can provide an effective treatment for the OCD patient. A dynamic therapist is in a good position to evaluate a patient's

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overall presentation. In the rare case that an OCD patient displays symptoms of a clear Axis I diagnosis of OCD, a good option may be to refer to an OCD specialist. However, such clear diagnoses are uncommon and characterlogical issues often complicate each individual case. A dynamic clinician may refer the patient for short-term CBT to help bring OCD symptoms under control, then later treat the patient dynamically. The third option is for the dynamic clinician to adopt some behavioral interventions and incorporate them into his/her treatment paradigm. An OCD patient with strong character-based resistance to CBT treatment may not benefit from CBT and medication alone.

Dynamic psychotherapy seems to be quite helpful in addressing character disorders, namely OCPD (Gabbard, 2001). Considering that many patients have components of both, and that symptoms often complicate interpersonal relationships, why not incorporate dynamic therapy with behavioral modification? Medication may also be necessary as it is usually indicated in any treatment model. "What is apparent is that one-dimensional models can no longer be maintained, nor is it likely that unidisciplinary research efforts will carry us much farther. The psychoanalytic study of psychopathology, like that of development, must be responsive to new knowledge generated in other fields" (Esman, 2001, p. 333).

Esman argues that psychoanalytic treatment is crucial for the treatment of OCD.

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> The psychoanalytic picture of obsessive-compulsive neurosis is in my view profoundly convincing in its delineation of the conflictual struggle of a patient in the here and now of daily experience and observation. The ambivalence, the desperate need for control, the struggles against what the patient experiences as forbidden wishes, the rigid and implacable quality of the internal prohibitions, the propensity for magical thinking, the confusion between thought and action-all of these are live and experience-near data which few sensitive observers could question. (Esman, 2001, p. 330)

Psychodynamic/psychoanalytic treatment can be effective in addressing characterlogical issues. As discussed earlier, OCD is not likely to occur in isolation without components of characterlogical issues that pose a challenge to treatment. Promising results have been cited in the analytic treatment of the obsessional character. "Some analysts have seen striking and lasting changes for the better in patients with obsessive-compulsive character traits, especially when the patients were able to come to terms with aggressive impulses behind their character traits" (Jenike, 2001, p. 10). "Conversely, there is no evidence that behavioral therapy and medications are helpful for patients with the personality

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disorder" (Jenike, 2001, p. 10). The relationship between OCD and OCPD is still unresolved and varying levels of OCPD may be found in OCD patients. For these reasons, a psychodynamic/psychoanalytic treatment approach is often indicated.

Extensive empirical research including studies consisting of brain imaging techniques, show remarkable before and after effects of behavioral treatment for OCD. However, results of behavioral treatment are typically more readily evaluated in outcome studies, building a greater body of evidence for behavioral treatment as effective. Many OCD patients steadfastly cling to their symptoms because of their special meanings and because of the interpersonal control they exert on others (Gabbard, 2001). As a result, such patients may be uninterested in doing the work of behavior therapy or complying with medication regimens. Problematic patients like this may be eliminated from many controlled trials because of their poor motivation or refusal to comply, and therefore empirical research on OCD may not adequately address this subgroup of patients (Gabbard, 2001). Addressing resistance or other dynamic circumstances leading to the patient's difficult nature may be treated more effectively psychodynamic/ psychoanalytically.

Furthermore, there may be a population that does not respond to behavioral treatment.

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> We must be mindful that a certain percentage of patients will respond to neither pharmacotherapy nor behavior therapy. A psychodynamic treatment approach may be necessary to deal with a treatment-refractory situation, even though the therapist must have modest goals for the improvement of the symptoms per se. OCD serves as a model illness to demonstrate the value of an integrated approach to the treatment of major psychiatric disorders. Psychodynamic strategies will continue to have a major role in psychiatry as illustrated by the many ways in which psychodynamic thinking is applicable to conditions such as OCD. (Gabbard, 2001, p. 219)

Gabbard (2001) recognizes the advances in biology and medicine as valuable contributions to treatment. While he agrees that a broad consensus has been reached that behavior therapy combined with an SSRI is most appropriate in the treatment of OCD symptoms, he stresses the importance of psychoanalytically informed treatment to address the dynamic components of OCD. As he noted earlier (2001), even though OCD symptoms may have biological underpinnings, they may be rich in dynamic meaning, and prone to exacerbation due to life stressors. Such meaning can be addressed through psychodynamic/ psychoanalytic therapy.

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Psychodynamic/psychoanalytic therapy can also be effective in addressing a patient's difficulties with family, friends, and other interpersonal relationships. The diagnosis of OCD is associated with a high rate of divorce (Zetin and Kramer, 1992). Psychodynamic/psychoanalytic therapy can be helpful in dealing with the stress brought to relationships by the illness. Identification of stressors and meanings of symptoms can aid some patients toward awareness of precipitating factors or events and to possibly reduce their impact (Gabbard, 2001).

Leib (2001) argues for psychodynamic/psychoanalytic treatment for OCD, but she stresses the importance of integration of behavioral modification, and medication. She warns that any of these treatments alone have shortcomings. She states that for at least a decade, psychoanalysis and psychodynamic psychotherapy alone have been "out of fashion" for the treatment of OCD. She views these dynamic treatment approaches as distinctly outside accepted standards of care in American psychiatry. She also asserts that a substantial body of literature demonstrates efficacy of both behavior modification and pharmacotherapy. There is an absence of research demonstrating the efficacy of dynamic psychotherapy alone in relieving the symptomatology of OCD according to Hales, Yudofsky, and Talbott, as cited by Leib. "Yet behavior modification and pharmacotherapy both yield symptomatic improvement in little more than half of treated patients, and relapse is frequent after discontinuation of treatment"

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(Leib, 2001, p. 223). While behavior modification and pharmacotherapy offer a good start to treatment, they are not always thorough enough in getting to the root of the symptoms, hence a fairly high relapse rate. Leib's hypothesis is that psychoanalysis, particularly if combined with the standard treatments (medication and some behavioral intervention), may provide a new opportunity for enhanced therapeutic results for many OCD patients.

The nature of the obsessive-compulsive symptoms is to avoid forbidden affects, wishes, and images, even at excessive costs. Working with such unconscious material is the hallmark of analytic treatment. As treacherous as the symptoms of OCD may be, the patient has chosen them over the forbidden material they defend against. Asking a patient to embark into territory of such material is not always realistic. Progress under an analytic model would likely be slow to start, if not impossible. A psychodynamic or analytic therapist may make use of some behavioral intervention and/or medication in order to bring about relief sooner.

Behavioral interventions may bring relief of symptoms sooner than interpretations alone by offering the patient compulsion reducing exercises (i.e. counting to reduce time spent while washing hands). Once the anxiety created by the symptoms themselves can be reduced, then it may be possible for the patient to work more analytically. If the behavioral treatment helps to relieve symptoms

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sooner, the patient may be able to hold greater faith in the therapy at a much earlier stage.

In summary, biopsychological, cognitive behavioral, and psychodynamic/psychoanalytic theories for the etiology and treatments for OCD have made enlightening contributions to date. However, these schools of thought present separate islands of ideas with few bridges to one another. Outcome studies make behavioral modification and pharmacotherapy appear to be most efficacious, although these results may be deceiving. The current body of analytic literature is significantly lacking in new ideas addressing OCD as an Axis I disorder. Yet, the dynamic therapist is uniquely suited to diagnose the complex symptom picture, and recommend what treatment, or combination of treatments is most appropriate. In the rare case of a clearly severe Axis I diagnosis of OCD, a dynamic therapist may choose to refer the patient out for behavioral/psychopharmacological treatment with the possibility of treating the patient later to address any underlying characterlogical issues. In most cases, the creative dynamic therapist may build an appropriate treatment for the OCD patient by combining medication, dynamic therapy, and behavioral modification.

Case Vignette

This case vignette is borrowed from Leib (2001) and incorporates analysis, behavior modification, and pharmacotherapy. Presented are aspects of the treatment of a patient with severe, disabling OCD. Leib first describes the

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patient, then the analysis and the introduction of drug therapy and behavior modification, and finally, how these non-analytic treatments were understood and worked with analytically. The patient presented was unusual in that she was not interested in rapid relief of symptoms. She was an example of an OCD patient who clung to her illness, first needing dynamic work to understand her resistance to treatment. For the sake of economy, I have paraphrased this case and have also added my own observations.

Rachel came to Dr. Leib insisting on psychoanalysis for treatment of her OCD. Rachel was well aware of the popularity of cognitive behavioral treatment and of SSRIs for treating her disorder. Adamantly opposed to being medicated, she did acknowledge the likelihood that eventually she would need to undergo behavior therapy. However, Rachel insisted that only analysis of the meaning of her symptoms would lead to her eventual recovery.

Rachel began treatment by phoning in and saying she would not be able to manage working with Dr. Leib if she had a dog. I would imagine that Rachel's insistence on analytic therapy was an early clue that her symptoms were laden with dynamic meaning. She was instantly controlling of her treatment, convinced of various assumptions, and quite obstinate. The fashion in which Rachel related to Dr. Leib created fertile ground for transference/countertransference interaction.

She first appeared in Leib's office wearing tall rubber boots, leather gloves, jeans, a sweater, and a large jacket that she did not remove. She made

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stiff and unnatural movements. She was tall with pretty features, in her early thirties. Rachel had short hair and wore no makeup. She was thin, drawn, and vaguely ill looking. She sat carefully, ensuring that her hands and clothing touched nothing.

Rachel claimed to be in robust physical and emotional health until three years prior when a distaste for the dog excrement left on the streets in her city neighborhood grew into a full-blown obsessive-compulsive disorder. She was focused on the possibility of being contaminated by "dogshit." She was consumed by her obsessions and compulsions, and was enraged at the insensitivity of dog owners who "selfishly allowed their beasts to foul the environment and thus trample the rights of others." She found the potential for contamination everywhere, in a splash from a puddle, on any carpet, mail from a contaminated part of the world, and so on.

The rituals to avoid these hazards were endless and had to be followed in some form by anyone who came near her as well. Her rituals involved the usual washing, cleaning, and avoiding. Rachel was resistant to leaving the house due to her fears of contamination. Her illness took over her and her husband's lives, while her husband remained supportive.

The vast majority of the early phase of treatment consisted of Rachel's unending, fully conscious rage at her mother. She was also angry with her father for not standing up to her mother and protecting Rachel and her siblings. Rachel

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blamed her parents for all her symptoms. Her mother was portrayed as intrusive and controlling to an extraordinary degree. She was described as very narcissistic, and neglectful. She reigned as queen of the household, passing down edicts, scolding violators, or becoming hysterical and enrolling Rachel's father for the job of enforcement and punishment.

Rachel's mother regulated the physical life of her children with brutal strictness. Only so many inches of bathwater were acceptable. Underwear was to be changed only so often. No choice of food was allowed. Any attempt to deviate from these rules was ridiculed as selfishness. Display of feminine pride in particular was quickly put down with public humiliation.

Rachel often offered her own interpretations of the symbolism of her symptoms. For example, dogs shitting represented her mother shitting all over her, either by tyrannizing her or imposing her mother's own psychotic-like level of anxiety. Dog owners who allowed their dogs to shit and didn't clean up represented her father, passive and impotent in the face of his wife's controlling rage.

Rachel had gotten herself lost in a metaphor. Although she knew the dogshit obsessions were a symbolic expression of her inner experiences, the metaphor had a life of its own, more meaningful and vital to her than anything else. This point in treatment exemplifies a patient's work to avoid addressing obsessive and compulsive symptoms. Rachel was caught up in analyzing various

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meanings on her own terms, but doing so intellectually. This effectively steers attention away from more difficult uncharted material. Leib initially allowed Rachel to maintain this level of control, helping her to feel more comfortable and trusting of the treatment.

It was crucial to Rachel that Leib understood how it had felt to be her mother's child – helpless, frustrated, enraged, ruined and shat upon. Leib's attention to the transference and countertransference led to a deeper understanding of Rachel's internal experience. Leib's support and validation deepened Rachel's trust, allowing for further work.

Leib's countertransference left her feeling controlled and inspected by Rachel, as if Rachael were peering inside her mind to see if it was clean enough. Leib felt fiercely judged. She understood this as Rachel's attempt at creating an experience that she had, being probed for moral righteousness and cleanliness by her mother. Later Leib could share this impression with the patient. Rachel was no longer consumed with having her perceptions validated and could appreciate how she had needed to turn the tables for Leib to be a stand-in mother.

The symbolic anality of Rachel's symptoms: rebellion, rage, stubbornness, control, shitting on, and being shat upon, was discussed at times, but of limited usefulness. Rachel was not quite able to acknowledge such forbidden parts of herself at this point. Her symptom structure allowed her to identify with and

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remain dependent upon her mother. It was suggested to Rachel that to stay ill was to never separate from her mother.

Rachel was quite powerful with her illness. She was demanding much attention and was a dictator for her own treatment. Mother had lounged about in bed and bath. Rachel was essentially lounging out her life in illness. She had been raised to work and serve others. Now she could do neither and, required others to serve her, i.e. pick up things she dropped, buy and prepare food, clean the toilets, and so on.

After the therapeutic alliance was well established, Rachel accidentally dropped a tissue on the floor of the office (a significant event in itself given her extraordinary vigilance). This event created a critical impasse. Leib realized that Rachel was ready to accept a more challenging level of engagement. Leib stated, "That's where I draw the line, I won't pick up your dirty Kleenex!" Rachel agreed with good-humored embarrassment that she did play the part of the queen, and then picked up the Kleenex. Later Rachel admitted that she was stunned and mortified by her need to be a queen. Her sense of selfishness and aggression were brought into consciousness. She couldn't bear this quality in herself and wanted to relinquish her grandiose position.

In regard to transference, there was much enactment of the tyrant/victim dyad. One had to be controlling the other. This was played out over medication, as Rachel resisted taking any medicine. This type of transference can be related

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to one of the most profound types of anxiety an individual can experience. The primitive anxiety of being controlled, invaded, or devoured by an omnipotent mother can leave an individual feeling helpless and impotent, as well as enraged. Rachel needed Leib to allow her controlling tyrant out and to have it tolerated without anxiety expressed by Leib.

Another phase of transference featured a warm, positive maternal transference, in which the patient readily acknowledged her need for encouragement, approval, and Leib's modeling of how to be a person, specifically a good woman. Ruptures in this transference, were inevitable, but relatively easily repaired.

In regard to pharmacotherapy, after some of the fervor of Rachel's position about medication had died down, Dr. Leib was able to ask her why she wouldn't want to try medicine, why any possible aid in alleviating her suffering wouldn't be eagerly taken up. This led to a painful, yet fruitful elaboration of her attachment to her illness. She was not sure she wanted or expected anything from life. Uncovered was more dynamic material leading to Rachel's underlying depression. Leib took a proactive position and insisted that Rachel take on everything that might help her get well. This included medicine, behavior therapy, and ultimately leaving the house to engage in more activities other than analysis.

After months of obsessional delays, Rachel took the medication, an SSRI. One month later they began behavior modification. A smooth progress including

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all three therapies began to take motion towards Rachel's improvement, making it difficult to separate which therapy was most helpful. After 15 months, the SSRI was discontinued with no apparent drawbacks.

The behavioral program they designed was a collaborative effort. The behavioral modification exercises took place during the first portion of the session and were tedious at times. Leib was usually the one to provide the push, but Rachel was willing to work and to be pushed.

Rachel began by exposing herself to contamination. She started touching the wall behind the couch, then the back of the couch. Doorknobs, chair arms, magazines in the waiting room, and so on eventually became integrated as she gradually expanded her field of mobility around the office. Several days or more were usually necessary for her to become comfortable with any given step. Soon Rachel would say what she would have to touch next. She'd frequently curse or groan while she was touching the "contaminated" thing, and good-humoredly maintained the stance that Leib was "making her".

The behavior therapy hit a plateau after some months when she had touched nearly everything around the office, except the floor. In order to move on, Rachel needed Leib to participate at a new level of activity. First, they played a game of throwing things at each other to catch (balls of Kleenex mostly) and then on the floor where Rachel would have to pick them up. Leib could choose

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where to throw them. Leib eventually chose to throw them to more highly traveled (and thus more threatening) areas of the carpet.

They both enjoyed the playing and finally had to face the most loaded activity, actually touching the floor. At this point, Leib joined her in the middle of the room and touched the floor too. Then they would touch their faces and hair getting fully "contaminated". It was crucial for Rachel to see Leib "contaminate" herself without any anxiety. Rachel would question in detail. "That really doesn't bother you?" "You don't feel dirty?" Leib was able to show Rachel that she was not the psychotically anxious mother placing demands of control upon Rachel.

The behavior therapy took about a year, meeting four times a week and spending 5-10 minutes a session, to get to the point where Rachel was comfortable touching the floor. Her ability to expand her activities outside the session progressed steadily in concert with the work, so that by the end of the year (and the end of three and one half years of analysis) her restrictions and compulsions specifically related to OCD were 80 percent gone.

In conclusion, psychoanalysis remained the primary treatment method. Adding behavior modification and medication seemed to have an enormous and essential effect on Rachel's improvement. Leib stated that this combining of modalities was surprisingly easy and fluid and in no way seemed to inhibit the depth or richness of the analytic work.

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It was quite evident that any one of the three kinds of treatment could be used as a resistance to any one of the other. For example, the overarching importance of analysis to Rachel served as resistance to the other treatments. Getting bogged down in a piece of behavior therapy could easily serve to divert from difficult analytic work or spare Rachel from painful affect other than the familiar anxiety caused by her OCD symptoms. Conversely, Rachel would on occasion present irresistibly ripe analytic material that drew attention away from a more difficult level in the behavioral component of her treatment.

The turning point in the analysis came when Leib recognized Rachel's deep, depressive commitment to her illness and her lack of investment in life outside her illness. At that time Leib also recognized that working alone on Rachel's behalf (without Rachel's investment for living) would have ultimately been fruitless. Rachel had never been permitted to have her own agenda and had fallen so deeply into an identification with her life-denying mother.

The central dynamic in OCD in Rachel's case was in relationship to internalized representations of a mother experienced as omnipotent, tyrannical, and dangerously controlling even to the ultimate point of not wanting her children to be vital, alive, whole, and autonomous. Not only helping Rachel to simply reduce her symptoms, Leib was able to provide Rachel with a new and healing maternal experience.

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Leib encourages a multimodal approach to the treatment of OCD. She states that the addition of the behavioral component is not necessarily complicated, only requiring the willingness on the part of the patient and analyst to participate. With adaptation to work in unfamiliar territory come opportunities to learn more about the treatment.

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Conclusion

Obsessive-Compulsive Disorder affects people of a variety of ages and across cultures. Obsessions are anxiety provoking recurrent thoughts, impulses, or images that are experienced as intrusive. Compulsions are repetitive behaviors such as organizing, washing, or checking, and are utilized to control obsessions.

Biopsychologists utilize brain-imaging techniques to locate brain regions with abnormalities specific to OCD. Cognitive psychology conceptualizes causes for OCD to be a result of cognitive misperceptions. Psychodynamic/ psychoanalytic perspectives conceptualize the disorder to be attributed to the management of unconscious anxiety and conflict.

The relationship between Obsessive-Compulsive Disorder and Obsessive-Compulsive Personality Disorder remains somewhat controversial. The DSM-IV differentiates the two while most of the analytic literature views them as closely related, stemming from an obsessional character.

Biopsychologists, cognitive behavioral therapists, and psychodynamic/ psychoanalytic therapists have compelling ideas for the etiologies and treatments for OCD. However, ideas from each school of thought are illustrated without collaboration to one another; there is no widely disseminated integrative approach. To date, cognitive behavioral treatment with medication is supported by empirical evidence as effective for OCD. Contemporary analytic contributions

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in the literature are disappointingly scarce; future progress is needed for the support of the analytic approach to OCD.

However, the dynamic therapist is typically quite apt to assess the complex presentation of each OCD patient as an individual. Once taking the complexities of an individual case into account, the dynamic clinician is in a vital position to recommend what treatment, or combination of treatments would be most appropriate for a given patient. In most cases, the creative dynamic therapist may build a treatment for the OCD patient by combining dynamic psychotherapy, medication, and behavioral interventions.

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