Lecture Notes: Obsessive Compulsive Disorder (OCD), Anxiety and Depression

Dr Jim Lucey is a Consultant Psychiatrist and Director of the Anxiety Programme at St. Patrick's Hospital, Dublin. He was the speaker for the April lecture in the 2006 Aware Monthly Lecture Series. The following notes are based on that lecture.

Dr Lucey began by showing the audience a headline which featured on the front cover of a previous issue of TIME magazine: "*Understanding Anxiety – now more than ever we are worrying ourselves sick*". Dr Lucey disagreed with this, saying it was untrue.

Anxiety is a normal phenomenon and is not new. Anxiety disorders reflect a series of disabling conditions. As your anxiety increases, your ability to function increases *up to a point*. In other words, the little bit of tension/anxiety helps. However, at a certain point increasing anxiety causes your function to collapse and this is when a person can become ill. **Depression** is an illness which prevents the individual from functioning and takes away the ability to live/work/play. When you are overwhelmed these functions and abilities are diminished. Blood flow to the brain decreases as anxiety increases.

Panic attacks involve thoughts of "oh my God I'm going to die" as well as physical symptoms such as cramps, weakness, defecation, hyperventilation and a feeling of being about to pass out. Those who have had a panic attack never forget the experience. A situation of avoidance can then result – the person does not want a repeat of the experience, so they seek to avoid the situation where it happened: "It happened on the bus, so I won't get on the bus again". If this avoidance continues, it can lead to agoraphobia. Many who experience panic attacks, will have depression as well, so which comes first?

56% Panic Disorder + Depression
37% SAD + Depression
27% OCD + Depression
62% GAD + Depression (Generalised Anxiety Depression)
42% Simple Phobia + Depression
48% PTS + Depression (Co-morbid)
Post traumatic stress disorder

Generalised Anxiety Disorder (GAD) involves an excessive anxiety and worry usually about a number of events or activities. Over a period of six months, the individual will have more days when this anxiety is present than not. There can be a great difficulty in controlling the worry and therefore it causes significant distress or impairment. There is not usually another general medical condition present, but patients will often present with associated symptoms such as difficulty concentrating, irritability, restlessness, muscle tension or fatigue.

Many of the physical symptoms of GAD will have emotional, cognitive and behavioural effects. For instance, an individual may experience physical

symptoms such as dry mouth, sweating and shortness of breath or hyperventilation. The emotional follow-on from such symptoms might include anxiety, panic and fear. The person might then begin to catastrophise and to have thoughts of impending doom. Their resulting behaviour might include hypervigilance, agitation or excessive safety behaviour.

Many individuals with GAD report that they have felt nervous and anxious all their lives. The average age of onset for this condition is 21 and its course can fluctuate, often getting worse during times of stress. For many people it can lead to significant functional impairment. GAD is highly co-morbid with depression and other anxiety disorders.

Treatment of Anxiety Disorder can be either pharmacological or psychological. CBT can be used as a treatment:

> “The past is history
> The future a mystery
> Let’s concentrate on NOW”

It puts the sufferer in charge: “I got myself well” as it involves cognitive restructuring. Pharmacological treatment can take eight weeks to work.

Obsessive Compulsive Disorder (OCD) is a type of anxiety disorder. OCD is characterised by distressing repetitive thoughts, impulses or images that are intense, frightening, absurd or unusual. These thoughts are followed by ritualised actions that are usually bizarre and irrational. These ritual actions, known as compulsions, help reduce anxiety caused by the individual's obsessive thoughts. Often described as the "disease of doubt", the sufferer usually knows the obsessive thoughts and compulsions are irrational but, on another level, fears they may be true.

Stigma
As with other mental disorders stigma is a huge part of anxiety disorders. Stigmatisation means the marginalisation and ostracism of individuals because they are mentally ill. Mental illness can be associated with shame and so stigma leads to people trying to conceal the illness and this in turn means a delay in seeking treatment. Ostracism does not just involve the individual who is ill – often it extends to the family involved and in some cases to those who treat them. There are many other elements of concern too: employment and housing discrimination can be devastating effects of having a mental illness. Often insurance benefits do not adequately cover mental health care, and fear of losing insurance cover can often deter people from getting help too.

In relation to anxiety disorders, it would seem that harming obsessions are more socially unacceptable than washing behaviours or cleaning.

There are a number of ways in which we stigmatise:

- Through ridicule
- Through denial
- Through shame
- Through alienation

- Through glamourisation
- In the media
- In advertising
- Stigma relating to treatment

Reducing Stigma

Although stigma is a huge problem, there are ways in which we can tackle it. Impartial handling of the illness is vital, as is effective treatment. The joint cooperation of patients, advocacy groups and professionals is also an important tool. Research into the nature of the illness will also go some way towards breaking down the myths and misunderstandings which surround this, and indeed all other, mental disorders.