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Anxiety and Related Disorders

Table of Contents

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Obsessive-Compulsive Disorder

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In this chapter, the DSM-III-R diagnostic criteria for obsessive-compulsive disorder are reviewed, and difficulties that can arise in the application of these criteria are considered. Specifically, we discuss: (1) the functional relationship between obsessions and compulsions, (2) whether neutralizing thoughts are obsessions or compulsions, and (3) the extent to which obsessive-compulsives recognize their obsessive fears as senseless. In addition, issues of comorbidity and differential diagnoses are reviewed. Specifically, we consider the relationship of obsessive-compulsive disorder to depression, simple phobia and generalized anxiety disorder, delusional disorder, hypochondriasis, obsessive-compulsive personality disorder, tic disorder, and impulse control disorders. Three case examples are included to illustrate the symptoms of OCD.

The symptoms that characterize the obsessive-compulsive disorder (OCD) have been described in the psychiatric literature for over a century. This unique condition has been known as religious melancholy (Maudsley, 1895), folie de doute (Janet, 1903), obsessional neurosis (Freud, 1909), and recently, obsessive-compulsive disorder (American Psychiatric Association,

1980). Once considered a rare disorder, the lifetime prevalence of OCD was recently estimated to be as high as 2% to 3% (National Epidemiology Catchment Area Survey; Robins et al., 1984). Even those who speculated that the methodology of the ECA survey led to inflated prevalence rates for some disorders have estimated the prevalence of OCD to be at least 1 to 2% (Rasmussen & Eisen, 1989).

According to the current Diagnostic and Statistical Manual of Mental Disorders (3rd ed.-rev.) (DSM-III-R; APA, 1987), the essential features of OCD are "recurrent obsessions or compulsions sufficiently severe to cause marked distress, be time-consuming, or significantly interfere with the person's normal routine, occupational functioning, or usual social activities or relationships with others" (p. 245). Descriptions of two representative cases follow.[1]

Case 1

> Alex is a 26-year-old white, married male with one child. He presented for treatment with extensive checking compulsions which he performed in order to prevent catastrophic events. When driving, he was obsessed with the idea that he might run over a pedestrian. In order to ensure that he had not done so, he constantly checked his rearview mirror so that he was unmindful of the traffic in front of his car, resulting in a car collision. In addition, he frequently retraced his route to further ensure that he had not hit anyone. Other obsessions concerned catastrophes that could befall his family due to his negligence. He repeatedly checked at home that appliances were off and/or unplugged, faucets were turned off firmly, and doors and windows were locked. When a criminal's physical description

matched his own appearance, Alex was consumed with obsessive fear that he would be blamed for committing the crime.

Alex recalled performing rituals as early as age 10 or 11 that over the years became increasingly disruptive. At the time of clinical presentation, his checking rituals were taking up to 4 or 5 hours per day. As a result of his checking, Alex was often late, and he avoided many situations that triggered the rituals: unnecessary driving, paying bills, leaving his home, and using the stove or oven. His OC symptoms disrupted his relationship with his wife and severely impaired his performance at work.

Case 2

Cindy is a 30-year-old, white, divorced woman with 3 children. Beginning in her early childhood, she developed obsessive fear of vomiting. She spent several hours each day cleaning herself and objects in her home in order to "kill germs" that might cause illness. In order to decrease exposure to germs, Cindy also avoided crowded places (especially where young children were present), doctors offices, hospitals, and other places she thought there might be sick people. She insisted that her children engage in the same washing and avoidance behavior to prevent them from becoming ill and passing the illness to her. Cindy also attempted to prevent illness and vomiting with "magical" thinking and rituals. For example, in her mind, the particular arrangement of her furniture was associated with good health in the family. Therefore, no one was permitted to move any furniture from its designated place. She also recited ritualistic set prayers each day to ensure her health.

Cindy traced the onset of her obsessive compulsive symptoms to age 5, after she had witnessed her sister vomit a large quantity of blood. Her concerns about illness and germs began shortly afterwards, and led to excessive handwashing as well as frequent refusal to attend school.

CURRENT CRITERIA FOR OBSESSIVE-COMPULSIVE DISORDER (OCD): A CRITICAL VIEW

Obsessions are defined in the DSM-III-R (APA, 1987) as repeated ideas, thoughts, impulses, or images that the person experiences as intrusive and senseless, and attempts to ignore, suppress, or neutralize with some other thought or action. Rasmussen and Tsuang (1986) and Rasmussen and Eisen (1989) reported that the most common obsessions, in descending order of prevalence, were contamination (e.g., becoming infected or spreading infection by shaking hands); aggression (e.g., having an impulse to attack or kill another person); pathologic doubt (e.g., repeatedly wondering whether one has performed some act such as turning off appliances or having left the door unlocked); somatic (e.g., worrying about the possibility of having a disease such as AIDs); need for having things in a particular order or arrangement (e.g., intense distress when objects are disordered or asymmetrical); and sexual (e.g., having an unwanted impulse to sexually assault another person).

Compulsions are defined as repetitive, purposeful, and intentional behaviors that the person feels driven to perform. They are usually carried out in response to an obsession or according to idiosyncratic rules and are intended to reduce or avert discomfort or some terrible event or predicament. However, either the behavior is not realistically related to its aim or the frequency of the behavior is excessive.

For example, individuals with obsessions about being contaminated by

urine or feces often feel driven to wash their hands and shower excessively; individuals with obsessions about doubting their performance as in locking doors or windows may be driven to check locks repeatedly. Examples of other common compulsions include counting, repeating actions, requesting reassurances, ordering and arranging objects, and hoarding (Rasmussen & Tsuang, 1986; Rasmussen & Eisen, 1989).

Foa and Kozak (1991) noted that the DSM diagnostic criteria for OCD have been influenced by several traditional concepts—some explicitly stated, some tacit. These include the ideas that (1) obsessions elicit subjective feelings of distress or anxiety; (2) obsessions and compulsions can be either functionally related or independent of one another; (3) obsessions are cognitive events (e.g., thoughts, ideas, images) while compulsions are overt behaviors (e.g., washing, checking); and (4) individuals with OCD recognize that their OC symptoms are senseless. Recent findings have suggested that some of these traditional views may require reevaluation.

Obsessions and Compulsions: Nature and Relationship

The first three issues are interrelated in that they are all concerned with the definition and function of obsessions and compulsions. The DSM-III-R reflects the view that obsessions are mental events and tacitly implies that they induce distress. One may surmise from the criteria that obsessions

arouse discomfort because the person seeks to "ignore, suppress, or neutralize" them (DSM-III-R; p. 247). Compulsions are overt behaviors that are intentional and purposeful. In addition, compulsive behavior is clearly described as reducing obsession-related discomfort, indirectly suggesting that obsessions cause discomfort. Clarification of these issues is critical in that they bear on treatment strategies as well as diagnostic considerations.

The view that there is an anxiety-related functional relationship between obsessions and compulsions was proposed by Hodgson and Rachman (1972), and reiterated by Foa and colleagues (Foa, Steketee, & Ozarow, 1985; Kozak, Foa, & McCarthy, 1988). Empirical support for the notion that obsessions induce anxiety is found in studies showing that ruminative thoughts elicit greater heart rate elevation and skin conductance than do neutral thoughts (Boulougouris, Rabavilas, & Stefanis, 1977; Rabavilas & Boulougouris, 1974). In other studies, both in-vivo and imaginal exposure to contaminants elicited increased heart rate, self-reported anxiety (Hodgson & Rachman, 1972; Kozak, Foa, & Steketee, 1988), and skin conductance responding (Hornsveld, Kraaimaat, & van Dam-Baggen, 1979).

Studies of OC patients have also demonstrated that compulsive behavior serves the function of reducing anxiety. Hodgson and Rachman (1972), reported that the act of washing after exposure to contamination resulted in decreased heart rate and self-reported discomfort. Comparable findings have

been reported with the performance of checking rituals (Carr, 1971; Roper & Rachman, 1976; Roper, Rachman, & Hodgson, 1973).

These data are consistent with the DSM-III-R criteria that imply a dynamic functional relationship between obsessions and compulsions. However, this appears to conflict with the concurrent idea presented in the DSM that compulsions may be independent of obsessions (i.e., "compulsions are . . . behaviors that are performed in response to an obsession or according to certain rules or in a stereotyped fashion" [italics ours] (p. 247).

Neutralizing Thoughts: Obsessions or Compulsions?

As noted, in the DSM-III-R, obsessions are described as mental events (e.g., thoughts, ideas, images) while compulsions are overt, observable behaviors (e.g., washing, checking, repeating actions). At the same time, the criteria for obsessions imply the existence of two types of mental events: unwanted, intrusive obsessions that the person attempts to ignore or suppress, and mental events that serve to neutralize the intrusive thoughts. This ambiguity is represented in obsession criterion A2: "the person attempts to ignore or suppress such thoughts or impulses or to neutralize them with some other *thought* or action" [italics ours] (p. 247). Thus some mental events seem to function as overt compulsions and can be referred to as cognitive rituals. However, in the description of compulsions, there is no

mention of cognitive rituals nor of the idea that thoughts can reduce or prevent distress.

Clinical observations suggest that individuals with OCD frequently report having cognitive compulsions, either alone or with ritualistic actions. Common cognitive rituals include silent praying, counting or repeating certain words or phrases to oneself, and mental reviewing of past events or conversations. For example, a person who has the obsessive fear that thinking "unclean" thoughts will lead to terrible consequences (e.g., acting on aggressive impulses, selling one's soul to the devil) may neutralize such thoughts by mentally reciting set prayers or thinking "good" thoughts. A person who fears that the number 9 is unlucky may silently repeat the "lucky number" 4 to counteract the anxiety associated with seeing the number 9.

A DSM-IV workgroup has endeavored to clarify issues related to the OCD diagnostic criteria and the definition and diversity of component symptoms. In a multi-site field trial, involving structured interviews conducted at several OCD clinics, the extent to which obsessive-compulsives reported having cognitive compulsions was investigated. The results indicated the presence of mental compulsions in the majority of obsessive-compulsives: about 79% of the sample reported having both behavioral and mental compulsions (Foa & Kozak, 1992).

Clarification of the DSM criteria may lead clinicians to increased awareness of cognitive rituals and to more accurate diagnoses. It is possible that some individuals who are considered "pure obsessionals" (i.e., those who manifest only obsessions in the absence of overt compulsions) may actually counter their obsessional distress with cognitive rituals, and therefore should not be considered purely obsessional.

Do Obsessive-Compulsives Recognize Their Symptoms as Senseless?

Another view that influenced the DSM-III-R diagnostic criteria for OCD is that obsessive-compulsive individuals maintain insight and recognize the senselessness of their obsessions and compulsions. In some of the early reports of the disorder (Westphal, 1878), the thinking of obsessive-compulsives was described as irrational or insane. However, Janet (1908) noted that obsessions were experienced as foreign to the personality and absurd. The latter view has clearly influenced successive DSM descriptions of OCD, despite reports that some obsessive-compulsives do not recognize that their symptoms are senseless or unreasonable (Foa, 1979; Insel & Akiskal, 1986; Lelliott, Noshirvani, Basoglu, Marks, & Monteiro, 1988).

Insel and Akiskal (1986) and Lelliott et al. (1988) have suggested that the strength of the patient's belief in the senselessness of obsessive-compulsive symptoms may represent a continuum. Some sufferers readily

admit that their symptoms are completely irrational; some are not convinced that their obsessions and/or compulsions are senseless. At the extreme end of the continuum are those who are convinced that their OCD symptoms are entirely sensible. Insel and Akiskal suggested that these individuals might best be described as having an "obsessive compulsive psychosis."

Commonly, the person's recognition of the senselessness of his or her symptoms varies across times and situations. For example, the person may recognize a compulsion to wash his or her hands 30 times as senseless when discussing it in a "safe situation" (e.g., the therapist's office), but not when distressed by an obsession or exposed to a contaminant. According to the DSM-III-R, recognition that the obsessions or compulsions are unreasonable is usually accompanied by a desire to resist (i.e., ignore, disregard, not engage in) them. Conversely, when the person does not demonstrate such recognition, there may be little or no resistance.

The question of whether obsessive-compulsives recognize the senselessness of their obsessive fears was explored in the DSM-IV field trial on obsessive-compulsive disorder. The results converged with the findings of the literature reviewed above: strength of belief in feared harm was broadly distributed in the OCD sample (Foa & Kozak, 1992). Among obsessive-compulsives concerned with disastrous consequences if they did not perform rituals, only 13% were completely convinced that their fear was senseless; at

the other extreme, 4% firmly believed that some harm would ensue if they did not perform rituals. The remainder of the sample reported intermediate degrees of certainty about the senselessness of their fears.

ONSET, COURSE, AND FAMILIAL PATTERN OF OCD

Most studies find that slightly more than half of those suffering from OCD are female (Rasmussen & Tsuang, 1986). The average age of onset of the disorder ranges from late adolescence to early twenties, although it typically occurs earlier in males than females. In a sample of 250 OC patients, Rasmussen and Eisen (1990) reported that peak age of onset for males was 13 to 15 years (around puberty) and for females it was 20 to 24 years. The onset of obsessive-compulsive disorder is typically gradual and insidious, but acute onset has been reported in some cases. For many

OCD sufferers, over seven years lapse between age of onset of significant symptoms and age of first presentation for psychiatric treatment (Rasmussen & Tsuang, 1986). Frequently, OCD patients endure many years of substantial impairment in social and occupational functioning before seeking treatment.

The clinical course of OCD is most often chronic with waxing and waning symptom severity. Episodic and deteriorating courses have been observed in 2% and 10% of patients, respectively (Rasmussen & Eisen, 1988).

Those with a deteriorating course were noted to have given up resisting OC symptoms and to manifest severe anxiety that did not habituate with flooding techniques.

Impairment due to OCD can be severe in both occupational and interpersonal spheres. Marital distress is common (Emmelkamp, de Haan, & Hoogduin, 1990), although it has been shown to improve following behavioral treatment for OCD (Riggs, Hiss, & Foa, 1991).

Genetic contributions to OCD have been evidenced by higher concordance of the disorder in monozygotic twins than in dizygotic twins, and by a high incidence of OCD in first degree relatives of individuals with the disorder (Pauls, Raymond, Hurst, et al., 1988; Swedo, Rapoport, Leonard, Lenane, & Cheslow, 1989). Rasmussen and Tsuang (1984) reviewed several studies and reported that of a total of 51 monozygotic twin pairs in which at least one twin had OCD, 63% were concordant for obsessive-compulsive symptoms. A study by Pauls et al. (1988), conducted with 100 OCD patients, indicated that up to 25% of first degree family members of OCD probands also manifested the disorder. An additional 17% had OC symptoms or features, but did not meet criteria for the disorder.

COMORBIDITY AND DIFFERENTIAL DIAGNOSIS

As frequently reported (Karno, Golding, Sorensen, & Burnam, 1988;

Rasmussen & Tsuang, 1986; Tynes, White, & Steketee, 1990), OCD commonly co-occurs with other symptoms and complaints. Depression, anxiety, phobic avoidance, and excessive worry are common, making differential diagnosis an important and often difficult process.

Depression

Numerous investigators have reported a clear association between depression and OCD (Foa, Steketee, Kozak, & Dugger, 1987; Karno et al., 1988). Rasmussen and Eisen (1989) reported that almost 70% of patients with OCD have a lifetime history of major depression. In their reported sample of 100 OC patients, 30% had a coexisting major depression upon admission, which was usually viewed as secondary to the interference of OCD symptoms in patients' lives. Based on the ECA study, Karno et al. (1988) reported that onset of OCD frequently precedes that of depression, and that about 30% of individuals with OCD met criteria for major depressive episode. Rasmussen and Tsuang (1986) found that 80% of their sample of 44 OCD patients evidenced symptoms of depression, and that three-fourths of these were secondary to OCD.

The presence of depressive disorders with OCD is important in that such co-occurrence may have implications for treatment. Some studies have suggested that a severe depression may interfere with the efficacy of

behavioral treatment of OCD (Foa, 1979; Foa, Grayson, Steketee, & Doppelt, 1983).

The co-occurrence of depression in OCD points the question of how to distinguish depression-induced rumination from the obsessions of OCD. Rumination about unpleasant life circumstances or problems is common and is considered a mood congruent aspect of depression rather than an obsession. Also, unlike the obsessions of OCD, this type of brooding is characterized neither by attempts to ignore or suppress the distressing thoughts nor by excessive anxiety (Rasmussen & Eisen, 1989).

Anxiety Disorders

The coincidence of obsessive-compulsive disorder with other anxiety disorders is high. Rasmussen and Tsuang (1986) reported that in a sample of 44 OC patients, lifetime incidence of simple phobia was 27%, social phobia was 18%, separation anxiety disorder was 18%, panic disorder was 14%, and agoraphobia was 9%. Using a sample of 468 individuals with a lifetime diagnosis of OCD, Karno et al. (1988) found that the co-occurrence of OCD and panic disorder was 13.8% and that of OCD and phobia was 46.5%.

The high rate of comorbidity with other anxiety disorders and anxiety symptoms can present diagnostic challenges. For example, generalized anxiety disorder (GAD) is characterized by excessive worry. Such worries are

distinguished from obsessions in that worries are usually excessive concerns about real life circumstances, and are experienced by the person as appropriate concerns. Accordingly, excessive concern that one may develop serious financial problems and lose one's home would be considered a worry, rather than an obsession. In contrast, the content of obsessions is likely to be unrealistic, and to be experienced as inappropriate and inconsistent with one's values. For example, an unwanted idea about losing control and stabbing someone, in the absence of a history of poor impulse control, would be considered an obsession.

To the extent that it depends upon a clinician's judgment about whether the content of an intrusive idea is realistic, distinguishing between worries and obsessions might seem at times problematic. In practice, however, the rituals that are so commonly associated with obsessions leave them readily distinguishable from the worries of GAD that are not accompanied by rituals. Thus, the issue of distinguishing between OCD and GAD on the basis of the content of an intrusive idea would arise only in the cases where there were no compulsions. Although the conventional wisdom is that the incidence of "pure" obsessionals is low, estimates have ranged up to 25% (Weiner, Reich, Robins, Fishman, & Van Doren, 1976). In the DSM-IV field trial for OCD, only about 2% of the OCD sample reported having obsessions without compulsions (Foa & Kozak, 1992).

Obsessions may occur as repeated thoughts about relatively low-probability, catastrophic events. These are typically events that are realistic and could possibly occur, but the individual focuses on, and magnifies, the minute risk of such occurrence. Examples of such exaggerations are fears of hitting a pedestrian while driving a car, or of developing cancer from exposure to household chemicals.

Individuals with contamination-related obsessions may appear similar to simple phobics in their symptoms. For example, people with either disorder may become terrified in the presence of dogs and avoid contact with dogs. However, there are at least two ways in which the OCD sufferer differs from the simple phobic. First, even if the feared object or situation is identical for both, the perceived threat or *reason* they fear it differs. Using the above example, dog phobics are typically afraid of being bitten. In contrast, an obsessive-compulsive patient typically fears dogs because they may carry diseases such as rabies or contaminants like feces. Secondly, because of the circumscribed nature of the fear (i.e., being bitten), simple phobics can successfully avoid or escape dogs and thereby reduce phobic distress. The threat perceived by a person with OCD is not eliminated by the removal of the dog because the contamination remains.

Since passive avoidance fails to reduce obsessional distress, the obsessive-compulsive person must actively ritualize in response to exposure

to the feared situation (e.g., washing hands, checking for illness after contact with a dog). Nevertheless, people with OCD frequently display fearful avoidance of situations that evoke the obsessions, such as being around dirt, bathrooms, or other sources of contamination. For example, a person with obsessions about germs may avoid public toilets; a person with obsessions about hitting people with a car may avoid driving. In severe cases, activity may be so restricted by avoidance that the individual becomes housebound and appears agoraphobic.

Delusional Disorders

According to the DSM-III-R, recognition of the excessive or unreasonable nature of OC behavior may not be present in young children or "people whose obsessions have evolved into overvalued ideas" (p. 245). Overvalued ideation is defined as an "almost unshakable" belief which can be acknowledged as potentially untrue only after extensive discussion. Their definitions notwithstanding, DSM-III-R does not provide formal guidelines for making reliable diagnostic distinctions between obsessions, overvalued ideas, and delusions. This can lead to diagnostic confusion because obsessive-compulsives evidence a continuum of strength of belief in the senselessness of their OC symptoms. The following case illustrates an obsessive-compulsive patient with impaired recognition of the senselessness of his obsessive fear.

Case 3

Chuck is a 28-year-old, white, single man. He sought treatment because his obsessive compulsive symptoms were interfering significantly with his educational progress. Pursuing a degree in nursing. Chuck was hindered by obsessive fear that he would fail to learn some critical piece of information that would be essential to his competence in future clinical practice. He was convinced that his deficient knowledge would lead to catastrophes such as patient death or disability, or even the death of whole groups of people by accidental poisoning. Other obsessions concerned fears of impregnating women via highly unlikely routes of transferring his sperm. For example. Chuck worried that if he masturbated in the shower and thoroughly cleaned the shower stall afterwards, some semen might remain on the walls or in some place that his female housemate might inadvertently touch. She would then get sperm on her hands and transfer it to her vagina, resulting in pregnancy. Chuck experienced many other obsessions that concerned fears of causing harm to others, such as spreading contaminants that would cause illness or death, and hitting someone with his car.

These obsessive fears led to extensive washing and checking compulsions. Chuck's handwashing and showering rituals occupied several hours per day. He avoided contact with very young, elderly, or sick people, which impeded his work in the hospital. His extensive checking for errors and perfectionistic, time-consuming study rituals occupied so much time that Chuck was unable to complete his course work or his required clinical practica in nursing school.

It became apparent through working with Chuck that he truly *believed* that his sperm could impregnate a woman via distal, nonsexual contact, despite assurance to the contrary by medical authority. Similarly, he was completely convinced that if he failed to acquire perfect mastery of all text and course work, it was highly likely that he would kill someone via negligence and incompetence.

This case clearly depicts an obsessive-compulsive patient who does not

recognize the senselessness of his OC symptoms.

Individuals with OCD who express strong convictions about their OC beliefs (i.e., exhibit "overvalued ideation") may have obsessions that are of a delusional intensity. In this case example, Chuck not only believed that it was possible to impregnate a woman via the transfer of sperm on objects like shower curtains, but also that his knowledge of this was special and superior (i.e., other people were just wrong about it). Delusional disorder is characterized by persistent nonbizarre delusions involving situations that occur in real life, such as being followed or having a disease. Because most obsessive-compulsives have both obsessions and compulsions, obsessions of delusional intensity can usually be distinguished from the delusions of delusional disorder by the presence of associated compulsions.

Obsessions may be extremely bizarre, such as the idea that the person might accidentally seal him or herself into an envelope and get deposited into a letter box. Although obsessional fears that are strongly believed, or that have strikingly bizarre content, may occur in individuals with OCD, these individuals do not show other symptoms of thought disorder or psychosis, such as incoherence or marked loosening of associations, hallucinations, flat or grossly inappropriate affect, and thought insertion or projection, unless there is a coexisting psychotic disorder. It has been suggested that overvalued ideas are associated with poor response to behavioral treatment (Foa, 1979),

but some investigators have been unable to document such a relationship (Lelliott & Marks, 1987; Lelliott et al., 1988). Thus, at present, the relationship between fixity of obsessive-compulsive beliefs and treatment outcome remains uncertain and merits further study.

Hypochondriasis

Hypochondriacal concerns are common in OCD, especially in individuals with illness- or disease-related obsessions (Rasmussen & Tsuang, 1986). Obsessive-compulsives with these concerns may exhibit somatic checking rituals and may repeatedly visit physicians to seek reassurance. Rasmussen and Eisen (1989) suggested that hypochondriacs with somatic obsessions and checking rituals should probably be diagnosed with OCD, but acknowledged that the differential diagnosis is often difficult.

In hypochondriasis, the individual has the unfounded belief that he or she has a disease and consults physicians for diagnoses and treatment. Illness-related obsessions of individuals with OCD are formally similar to those of individuals with hypochondriasis. If the symptoms consist only of preoccupation with the person's own health and excessive information-seeking about health and/or treatment, a diagnosis of hypochondriasis is most likely appropriate. If other obsessions and/or compulsions are present in addition to concerns for one's own health then a diagnosis of OCD is

indicated. For example, the presence of obsessions about spreading illness to other people, or of rituals such as excessive handwashing or checking, indicate a diagnosis of OCD.

A disorder which appears similar to hypochondriasis is body dysmorphic disorder (BDD). The essential feature of BDD is an obsessive preoccupation with an imagined physical defect in a person with essentially normal appearance. For example, a person may believe that his or her ears are hideously and abnormally large and should be surgically repaired, but to others the ears are unremarkable. Body dysmorphia is sometimes coupled with compulsive checking behavior. In the above example, the individual may feel compelled to ask everyone if his or her ears are too large.

If other obsessions or compulsions are present in a person with body dysmorphic disorder, a diagnosis of OCD may be indicated. In part on the basis of positive response to serotonergic drug treatment in 5 cases of BDD, Hollander, Liebowitz, Winchel, Klumker, and Klein (1989) suggested that this disorder may be closely related to OCD. More research is needed to investigate such a linkage.

Personality Disorders

The essential feature of obsessive-compulsive personality disorder (OCPD) is a “pervasive pattern of perfectionism and inflexibility” (DSM-III-R;

p. 354), characterized by preoccupation with details, unreasonable insistence that others do things his or her way, excessive devotion to work, indecisiveness, overconscientiousness, restricted expression of affection, stinginess, and inability to discard worthless possessions. Tynes et al. (1990) noted that while the only criterion from this list that overlaps with a common OCD symptom is hoarding, the general traits of perfectionism and inflexibility do appear characteristic of many individuals with OCD.

Jenike and Baer (1990) argued that there is no evidence that OCD predisposes to OCPD or vice versa, nor that individuals with OCD are more likely to have OC personality disorder than any other Axis II disorder. Nonetheless, estimates of the co-occurrence of DSM-III-R diagnosed OCPD and OCD range from about 5% to 25% (Joffe, Swinson, & Regan, 1988; Jenike & Baer, 1990). Jenike and Baer attributed this variability in part to the inconsistent and subjective process of personality evaluation and lack of agreement among assessment devices. A traditional basis for the differential diagnosis has been whether the symptoms are "ego-dystonic" (e.g., experienced as unwanted, foreign) as in OCD or "ego-syntonic" (e.g., consistent with one's self-concept, valued) as in OCPD. Rasmussen and Eisen (1989) suggested that this distinction is insufficient and sometimes inaccurate. They noted the incidence of patients with severely impaired functioning due to OC symptoms who still maintain that their concerns and behaviors are important and/or reasonable.

There is empirical support to suggest that Axis II disorders are more likely to occur in individuals with OCD than in the general population. In their sample of 44 OCD patients, Rasmussen and Tsuang (1986) found that 29 (66%) exhibited at least one personality disorder: 55% met criteria of OC personality disorder, 9% met criteria for histrionic, 7% for schizoid, and 5% for dependent personality disorder.

Tic Disorders

Repetitive, stereotyped behavior is evident in both Tourette's Syndrome (TS) and tic disorder, but is distinguished from compulsive behavior in that it is generally involuntary and purposeless. Tourette's syndrome is characterized by both motor and vocal tics. A high incidence of OCD in individuals with TS has been documented, with estimates ranging from 36% to 63% (Leckman & Chittenden, 1990; Pauls, Towbin, Leckman, Zahner, & Cohen, 1986; Pitman, Green, Jenike, & Mesulam, 1987). The incidence of TS in OCD is lower, with estimates ranging between 5% and 7% (Rasmussen & Eisen, 1989). However, simple tics are frequently observed in those with OCD. Pauls (1989) reported that 20% to 30% of individuals with OCD admitted the presence of current or past tics.

Further evidence of a relationship between OCD and Tourette's syndrome comes from family studies. About 10% of first degree relatives of

Tourette's syndrome probands had TS, about 20% had tic disorder, and about 20% had OCD (Pauls et al., 1986).

Eating and Impulse Control Disorders

Coincidence of OCD with eating disorders, such as anorexia nervosa and bulimia nervosa, has been noted. According to Kasvikis, Tsakiris, Marks, and Basoglu (1986), about 10% of females with OCD have had a history of anorexia nervosa. The coincidence of OCD with bulimia nervosa is more striking: between 33% and 66% of bulimics had a lifetime incidence of OCD (Hudson, Pope, Yurgelun-Todd, Jonas, & Frankenburg, 1987; Laessle, Kittl, Fichter, & Wittchen, 1987).

Over-eating and other problem behaviors such as gambling, substance abuse, trichotillomania (hair pulling), and kleptomania are often described as compulsive in nature. Most if not all of these disorders are characterized by a sense of compulsion to carry out an act that the person typically admits is unreasonable or self-destructive.

According to the DSM-III-R, what distinguishes such pathological behaviors from "true" compulsions is that rather than serving only to reduce tension, they elicit a subjective sense of pleasure or gratification. However, some investigators oppose a distinction made on this basis. Dar, Omer, and Griest (1992) suggested that OCD, bulimia, alcohol and substance abuse, some

paraphilias, and impulse control disorders are all members of a compulsive spectrum. They argued that these disorders are elements of a compulsive spectrum for three reasons: they share a common phenomenological picture with specific emotional/motivational, cognitive, and behavioral aspects; all show response to the same treatments (pharmacologic and behavioral); and all are consistent with a single unified conceptualization or underlying mechanism.

CONCLUSION

In this chapter, we have reviewed the characteristics of OCD and described several cases that illustrate the range of symptoms that are manifested in this disorder. We have examined several traditional concepts that are present in the DSM-III-R diagnostic criteria for OCD and highlighted their shortcomings. The available data suggest that some of these traditional concepts are unsupported, and that certain aspects of the DSM-III-R diagnostic criteria could be improved.

We have concluded that the available research supports the DSM-III-R emphasis on a functional relationship between most obsessions and compulsions. The data also suggest that a minority of obsessions and compulsions are unrelated and this supports their independence. We have, however, challenged the traditional notion that obsessions are mental events

and compulsions are overt behaviors; the available evidence is inconsistent with this idea. Finally, we argued that obsessive-compulsives show a broad range of recognition of the senselessness of their OC fears and that is important for the clinician to know that not all individuals with OCD view their symptoms as senseless.

In this chapter, we also discussed issues of comorbidity and differential diagnosis. The literature suggests extensive comorbidity of OCD and depression and other anxiety disorders. Hypochondriacal concerns, personality disorders (perhaps especially obsessive-compulsive personality disorder), tic disorders, and eating disorders also co-occur with OCD with significant frequency. We concluded the chapter with brief mention of the view that OCD is one of several disorders in a "compulsive spectrum" of pathology. The potential advantage of this view in advancing our knowledge of the etiology and treatment of OCD needs to be explored in future research.

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Notes

[1] Although they represent actual cases, certain details and information were modified in the three patient descriptions presented in this chapter in the interests o f patient confidentiality