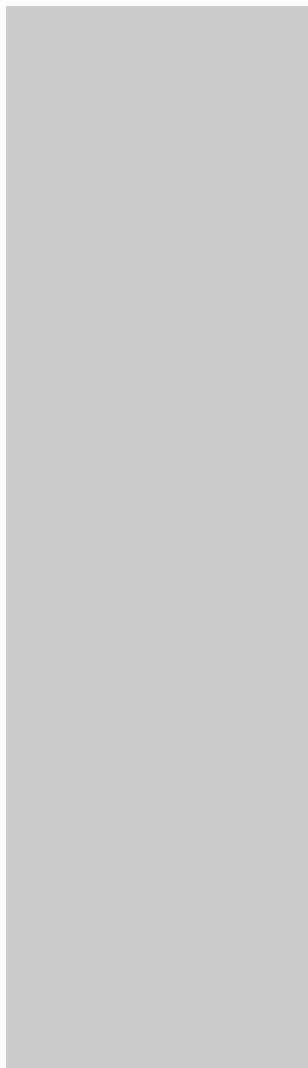


SECTION I



THE NATURE OF OCD





Chapter 1

THE CLASSIFICATION AND DIAGNOSIS OF OBSESSIVE-COMPULSIVE DISORDER

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This opening chapter will endeavour to provide an historical account of obsessive-compulsive disorder (OCD), and will also examine contemporary diagnostic and classificatory issues. The similarity of OCD to a number of other disorders, including the degree of co-morbidity with these, will also be addressed. Finally, a close examination of the epidemiology of the condition will be provided.

HISTORICAL OVERVIEW

The symptoms of OCD have been identified, with some consistency, from as early as the seventeenth century. At this time, obsessions were considered to exist purely within a religious framework and sufferers were considered to be possessed by outside forces, such as the devil (Salzman & Thaler, 1981). Not surprisingly, the most popular treatment method was exorcism, which, by all reports, resulted in some cases of therapeutic success. While little is known about the type of compulsive behaviour that dominated clinical presentations in this period, it is noteworthy that washing/cleaning behaviours have been clearly described from the earliest literature. Perhaps the first fictional portrayal of OCD is Shakespeare's illustration of Lady Macbeth in the sixteenth century. As we all know, this character, in an attempt to rid herself of guilt, repeatedly engaged in hand washing, a behaviour which continues to dominate much of the contemporary literature on the condition.

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By the early part of the nineteenth century, OCD had moved from the spiritual to the medical field of enquiry. The condition was considered to be a variant of 'insanity', a construct earlier introduced and defined by a number of French psychiatrists. Esquirol (1838) was the first to argue that, since his patients were aware that their obsessions were irresistible, they possessed a certain degree of insight. Thus, the emergence of 'neurosis' began during the early 1800s, a notion further developed when Morel described OCD as a 'disease of emotions'. He used the word 'delire' to allow for the unconventional reference to the presence of insight. Towards the end of the nineteenth century, Legrand du Saulle described OCD as an insanity with insight, but suggested that psychotic symptoms could be present (an issue that was later to become a contentious one in differential diagnosis). Of course, at this time, OCD, phobias, panic and other somatic symptoms were not well differentiated, further confusing the definition and description of OCD.

Across Europe, these early descriptions of OCD focused on differing aspects of the disorder, and were dependent largely on prevailing cultural issues in the homeland of the writer. While the English concentrated on the religious perspective of OCD and viewed the disorder as a melancholic illness, the French stressed the loss of will, or volition, and identified anxiety at the heart of the disorder. German writers, such as Westphal (1878), identified irrational thoughts as neurological events that had a cognitive representation.

These early European descriptions of OCD, especially the French and German perspectives, paved the way for the psychological perspective that was to emerge from the beginning of the twentieth century. Until this time, OCD was considered a medical condition, which warranted treatment within a medical framework (Rachman & Hodgson, 1980). It was only when clinical psychology emerged from the existing framework of clinical psychiatry that a non-pathological, non-religious view of OCD was clearly offered. Drawing on the research by Legrand du Saulle, Janet (1903) was the first to put forward the psychological view of obsessive-compulsive neurosis. He proposed that all obsessional patients possessed an 'abnormal' personality, with features such as anxiety, excessive worrying, lack of energy and doubting, and described successful treatment of compulsive rituals consistent with the later development of behaviour therapy (Jenike et al., 1998a; Rachman & Hodgson, 1980).

At around this time Freud (1896) proposed a revolutionary theory for the existence of obsessional thinking in which he defined obsessional ideas as 'transformed self-reproaches which have re-emerged from repression and which always relate to some sexual act that was performed with pleasure

in childhood' (Freud, 1896, p. 169). This suggestion was formulated predominantly from his experience with patients at the turn of the nineteenth century. Although Freud saw a number of patients whom he considered to be suffering from obsessional neurosis, much of his thinking (and writing) on OCD was based on the now famous 'Rat Man', a case which will be briefly outlined below.

The patient, a youngish man of university education, told Freud that he had suffered from obsessions since early childhood. As a child, he had experienced an unnatural obsession about the death of his father (having believed that he had the power to control his father's general well-being). Without apparent questioning, the patient proceeded to discuss his infantile sexuality. From an early age, he expressed the wish to see girls naked and had a desire to touch them. Accompanying this desire was the feeling that if he did not prevent such thoughts, his father might die. The patient subsequently developed certain impulses that he believed would be effective in warding off the impending evil. These 'impulses' are now more commonly known as compulsions that serve to reduce the anxiety associated with his obsessive thinking.

Later in this patient's life, he came across a senior officer who conveyed a form of punishment that was extremely unnerving to him. This particularly horrendous method of torture involved the criminal being tied up and then having rats placed under a pot, which was turned upside down on the man's buttocks. The rats, having no means of escape, slowly bore their way into the man's buttocks (Freud, 1909). Although the patient expressed horror as he conveyed this story to Freud, Freud interpreted it as one of 'horror at pleasure of his own of which he himself was unaware' (p. 167). The precipitating cause of this man's obsessional thinking was never clearly identified by Freud or by the patient himself. Freud (1909) argued that the 'infantile preconditions of the neurosis may be overtaken by amnesia... though the immediate occasions of the illness are... retained in the memory' (pp. 195-6).

In a second illustrative example of OCD from the dynamic perspective, Freud (1909) described the symptoms of a patient who displayed an obsession with cleanliness. This particular individual was a government official who always presented crisp paper notes as payment. Freud remarked that that they were distinctive because they were always clean and smooth. The patient replied that he had ironed them at home for fear of contracting an illness from the bacteria on the notes. Because of Freud's suspicion of a link between the neuroses and infantile sexuality, he enquired about the patient's sexual life. The patient replied that he found it gratifying to masturbate a number of young women with his hands. To this Freud replied,

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'but aren't you afraid of doing (them) some harm, fiddling about in (their) genitals with your dirty hand?' (p. 197). The patient was horrified and remarked that it had never done any of the girls harm. On the contrary, he claimed, they had enjoyed the activity. Freud believed that this patient was able to justify his inappropriate sexual behaviour by the displacement of his self-reproach and, in line with his theory, assumed that the patient's sexual gratification was 'probably impelled by some powerful infantile determinants' (p. 198).

Instead of a medical treatment regime typical of the late nineteenth century, Freud opted for psychoanalysis, an attempt to resolve past conflicts in the afflicted individual by appealing to the unconscious. However, this form of treatment did little to improve the outcome of OCD patients (Jenike et al., 1998a). An important distinction was also made. Freud believed that obsessive-compulsive neurosis existed as a syndrome separate from the 'anal-erotic' character. The latter syndrome, according to Freud, predisposed an individual to the development of OCD. It is this distinction, as discussed later in this chapter, that (in part) led to the present-day differentiation of OCD and obsessive-compulsive personality disorder (OCPD).

The most significant theoretical developments in the period since Freud are undoubtedly the emergence of the neurobiological and psychological/cognitive perspectives. Since they, along with the treatments that stem from them, will be described in detail in various chapters that follow, they will not be dealt with here. Instead, attention will turn to the classification of the disorder, which, along with improvements in assessment, may be regarded as the other significant development in the area in the twentieth century.

CLASSIFICATION OF OCD

Contemporary attempts at the classification of OCD are now governed by two systems, the *International Classification of Diseases*, 10th Revision (ICD-10) and the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edn (DSM-IV; APA, 1994). Although the ICD-10 (WHO, 1992) is regarded as the official coding system in many countries, the DSM-IV (APA, 1994) is the more popular amongst mental health professionals (Andrews et al., 1999).

Current Classification According to DSM-IV

The DSM-IV (APA, 1994) describes OCD according to five diagnostic criteria. The principle features of the disorder are: (a) recurrent thoughts, or images (termed 'obsessions') that are considered intrusive and that cause significant distress; and (b) ritualistic behaviours (termed 'compulsions')

typically engaged in to rid or neutralise obsessive thoughts. Although it may be difficult to ascertain the degree of distress, the DSM-IV maintains that an individual must experience a significant disturbance in normal functioning, or engage in obsessive-compulsive activity for at least 1 hour/day, to be given a diagnosis of OCD. Further, the individual must, at some point during the course of the disorder, recognise the irrationality of his/her thoughts and behaviour. A specification of poor insight may be added to the diagnosis of OCD when an individual does not currently recognise that the obsessions and compulsions are excessive or unreasonable.

Previously, a diagnosis of OCD implied that the individual could generally recognise that his/her fears were irrational or unreasonable throughout the life of his/her disorder (Enright & Beech, 1997). It was only in DSM-IV that a 'poor insight' specification was added in order to account for a number of individuals who appear to fail to accept the senselessness and futility of their obsessive and compulsive behaviours. The addition of this category in the diagnosis of OCD may be considered favourable from a treatment perspective, since it is well established that individuals with a strong conviction that their fears are realistic have poor outcomes in behavioural programs (Foa, 1979). However, a number of writers have argued that the added specification of 'poor insight' does not help to clarify the distinction between OCD and other disorders. In fact, it may further complicate classificatory difficulties as it introduces a new problem. OCD sufferers with poor insight, or overvalued ideas, must now be distinguished from individuals with delusional beliefs. DSM-IV dictates that OCD should be diagnosed when 'an individual whose extreme preoccupation . . . although exaggerated, is less intense than in a Delusional Disorder' (APA, 1994, p. 422). But what is 'less intense' and how may it be defined?

In sum, the addition of 'poor insight' to the diagnosis of OCD brings about a number of difficulties that render the differential diagnosis of this disorder problematic. In order to establish a clear-cut definition of OCD, these concerns need to be considered. The following section will address: (a) the question of the classification of OCD as an anxiety disorder; and (b) the significant degree of overlap with a number of other disorders, e.g. the obsessive-compulsive spectrum disorders, the mood disorders, the personality disorders, and the schizophrenic disorders.

OCD AND THE ANXIETY DISORDERS

Ever since the introduction of the DSM-III, OCD has been classified amongst the anxiety disorders. However, the substantial overlapping

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features and high co-morbidity rate of OCD with other anxiety disorders complicates the diagnosis of OCD.

Distinctions between OCD and GAD

First and foremost, the greatest difficulty in the differential diagnosis of OCD and generalised anxiety disorder (GAD) lies in the distinction between worry and obsession. A number of researchers have attempted to clarify this distinction but there is little evidence to suggest that worry and obsessions do not simply reflect the same mental process (Turner 1992). The only distinguishing feature between these concerns offered by the DSM-IV (APA, 1994) appears to rest on the consistency or duration of distress for sufferers of the two conditions. Worry appears to be a more drawn-out or consistent concern in GAD than does obsession in OCD, in that the former must 'occur more days than not for at least 6 months'. Descriptions of obsession imply a recurrence and persistence in thought but do not include any given time duration. In terms of the level of disturbance, there appears to be no distinction. Andrews et al. (1994) argue that the most important distinguishing feature is that the *content* of worry/obsession may be regarded as different in these two disorders. These authors argue that individuals suffering from GAD are primarily concerned with everyday issues (e.g. family, health or occupational issues that may be deemed 'appropriate'), whereas OCD sufferers frequently report unusual themes concerning dirt and contamination, aggression, hoarding and religion.

But is a distinction based simply on 'content' areas adequate? Is it possible (and clinically valid) to distinguish between everyday worries and other concerns? For example, if an individual expresses worries about the possible contamination of her child, is this concern different from a 'family or health concern' frequently reported by patients with GAD?

Important also is the notion of 'rumination' and its distinction from typical obsessional activity in OCD and worry amongst patients with GAD (see further discussion in Chapter 11). De Silva & Rachman (1992) have noted that the content of ruminatory thoughts tend to concern religious, philosophical or metaphysical subjects, which, once again, may tend to prove difficult to distinguish from obsessive thoughts or generalised worry. However, de Silva & Rachman (1992) have noted that, unlike obsessions, ruminations do not intrude into the patient's consciousness in a well-defined form or with a clear or repetitive content. In fact, some have argued that ruminations appear to be more frequently 'cognitive compulsions' because of their ability to briefly ameliorate anxiety (Foa et al., 1985). However,

not all agree, with several authors arguing that rumination (somewhat like worry), may not always reduce anxiety in the way that compulsions (whether behavioural or cognitive) reliably appear to (see further discussion in de Silva & Rachman, 1992; Chapter 11, this volume).

Andrews et al. (1994) state that individuals with OCD regard their thoughts as 'unacceptable', whereas those with GAD are more likely to consider their issues realistic (since they focus on common fears/issues in the community). However, this statement is debatable. Although some individuals with OCD might agree that their thoughts are unacceptable, there are a number who argue that their beliefs are completely reasonable, as described earlier in this chapter. The added inclusion of the 'poor insight' subgroup in OCD in the DSM-IV (APA, 1994) clearly clouds the distinction between certain presentations of OCD and GAD.

Distinction between OCD and Phobias

Rachman & Hodgson (1980) have suggested that OCD and the phobic disorders share a number of similar features. These include avoidance behaviours, fear reactions in response to specific stimuli or situations, and a particularly successful response to behaviour therapy. In fact, it is clear that exposure with response prevention for OCD and graduated exposure for phobias are essentially the same treatment. The treatment method for the phobic disorders involves confrontation of the eliciting stimulus and also prevents the response, i.e. escape behaviour. In addition to these similarities, Rasmussen & Tsuang (1986) found that a substantial proportion of individuals with OCD had a history of simple phobia.

Despite these similarities, Enright & Beech (1997) have identified a number of distinguishing features between these two disorders. First, individuals with OCD will have persistent and recurrent thoughts about a feared stimulus/situation in the absence of this feared image/event. Phobic patients typically do not experience any distress in the absence of phobic stimuli. Second, and more important to the distinction, is the absence of ritualistic behaviour in the phobic disorders. Phobic patients routinely avoid their feared stimulus, whereas individuals with OCD are not confined solely to avoidance. More common is the ritualistic behaviour displayed in response to an obsession, which is triggered internally. However, if one considers the 'rituals' in OCD and 'escape-avoidance' in phobias as the same in terms of their purpose (i.e. removing an aversive stimulus), then a distinction between these disorders (in this regard) becomes less clear.

OCD AND OBSESSIVE-COMPULSIVE SPECTRUM DISORDERS

There are many disorders categorised in the DSM-IV that share close phenomenological similarities to OCD, and they have become popularly known as the obsessive-compulsive spectrum disorders. This approach, as discussed at length by Veale (see further, Chapter 13), is somewhat problematic, since almost a half of the DSM-IV may be viewed in this way. It is questionable whether the notion of OCD spectrum disorders has advanced our understanding of the conditions concerned. However, for completeness, some coverage of these conditions is warranted in the present chapter.

Lists of OCD spectrum disorders typically include Tourette's syndrome, hypochondriasis, body dysmorphic disorder (BDD), the impulse control disorders (e.g. trichotillomania, kleptomania) and the eating disorders. A number of these will be outlined in an attempt to clarify the distinction between OCD and these related disorders. As the spectrum disorders (and particularly BDD) are covered at length in Chapter 13, relatively little attention will be given to them in the following section. In the present chapter, only sufficient coverage of these disorders will be given to identify relevant diagnostic issues.

OCD and Tourette's Syndrome

OCD and Tourette's syndrome share a number of similarities including a high co-morbidity rate and a substantial overlap of clinical features (Hollander & Benzaquen, 1997; Steingard & Dillon-Stout, 1992). On the surface, it may appear that overt rituals in individuals with Tourette's syndrome resemble compulsive rituals in OCD. However, the nature of these behaviours can be differentiated. Stereotyped motor behaviours associated with tic disorder and Tourette's syndrome are involuntary and unintentional behaviours. These may be clearly distinguished from the ritualistic behaviours that an individual with OCD is compelled to perform in order to reduce the threat associated directly with his/her obsessions.

OCD and Hypochondriasis

Clinical experience and research suggests that there may be a subgroup of hypochondriacal individuals who seem more aligned to the anxiety disorders than to the somatoform disorders (Barsky, 1992). Indeed, hypochondriasis and OCD appear to share a number of similar features. The DSM-IV

(APA, 1994) defines hypochondriasis as a 'preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms' (p. 465). This definition appears somewhat consistent with the OCD subtype involving contamination/illness concerns. A number of similarities have been identified by Barsky (1992), including: (a) the content of the preoccupation; and (b) the similar nature of reassurance-seeking behaviours in hypochondriasis and compulsive rituals in OCD. Several distinguishing features, however, are apparent on closer examination. First it must be recognised that the main reason for the inclusion of hypochondriasis amongst the somatoform disorders is that somatic, or physical, sensation must be experienced. OCD, in contrast, does not typically involve aberrant bodily sensations. Second, the interpersonal dimension of these disorders differs substantially. Individuals with OCD are generally secretive about their disorder and tend to conceal it from public knowledge. Hypochondriacal patients will often vocalise their distress in an attempt to justify the seriousness of their perceived illness. Finally, no attempt is made to neutralise or resist thoughts about disease and illness among hypochondriacal patients. In stark contrast, individuals with OCD fiercely attempt to ignore, suppress and resist their obsessional beliefs.

OCD and Body Dysmorphic Disorder (BDD)

Since BDD forms the basis of Chapter 13, we will restrict our comments here. The disorder is categorised by a preoccupation with an imagined defect in one's physical appearance, which causes marked distress to an individual that subsequently impairs social and occupational functioning. Hollander & Benzaquen (1997) have found a 37% co-morbidity of OCD with BDD, suggesting some degree of overlap amongst these disorders. Although not formally necessary for a diagnosis, compulsive checking is typically found amongst BDD patients. Furthermore, these disorders share the same structure, in that individuals with either disorder experience intrusive thoughts that cause anxiety and distress (Goldsmith et al., 1998). Given that the symptom profile of these disorders is similar, BDD is often misdiagnosed as OCD.

Despite this similar symptom profile, however, Hollander & Benzaquen (1997) have identified a number of distinguishing features between these disorders. These include the ideational content, complexity and frequency of beliefs. Most importantly, BDD preoccupations typically revolve around self-appearance, whereas OCD concerns generally involve the overestimation of threat or harm. However, as argued earlier, one must be cautious when distinguishing between disorders on the basis of ideational content.

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For example, it may be possible to interpret BDD as an obsessional over-estimation of threat or harm (i.e. in the form of social threat). These and related issues are examined at length in Chapter 13.

OCD and Impulse Control Disorders (e.g. Trichotillomania)

It may be tempting to classify the impulse control disorders under the category of OCD, given their similarity with respect to subjective urges and subsequent anxiety relief upon completion of relevant behaviours. However, Andrews et al. (1994) argue that they may be differentiated, since the behaviours employed in OCD are not ego-syntonic (i.e. the rituals *per se* are not considered to be gratifying in any way). Hollander & Benzaquen (1997) have provided a similar distinction between compulsivity and impulsivity. These authors maintain that compulsive activity is the means by which discomfort is decreased, whereas impulsivity involves the eliciting of pleasure. Trichotillomania, for example, is an impulse control disorder where an individual typically derives some pleasure or gratification from the activity of hair-pulling. In contrast, sufferers of OCD typically report that the only relief or satisfaction felt from compulsive activity arises from the elimination of any associated anxiety. Stein et al. (1995a) propose an added distinction between these disorders. OCD patients often describe that their compulsive behaviour is a direct response to their obsessions. However, these authors argue that individuals with trichotillomania do not appear to have a clear obsession that precedes their hair pulling (although in our clinical experience, these individuals may occasionally harbour threat-based beliefs about the colour, shape or feel of particular hairs). Finally, in our clinical judgement, trichotillomania is easier to stop, the hair pulling often ceasing in 1 or 2 sessions of behavioural monitoring (perhaps because it lacks the clear, overvalued obsessional component of OCD).

OCD and Eating Disorders

Eating disorders are regarded as part of the obsessive-compulsive spectrum disorders, due to their core abnormal thoughts and behaviours (Goldsmith et al., 1998). The excessive fear of gaining weight and the pre-occupation with food and weight are obsessional and compulsive features that are reminiscent of those displayed in OCD. Furthermore, both these disorders possess a similar course, substantial co-morbidity and a similar response to medication-based treatment (Goldsmith et al., 1998). However, many authors argue that the eating disorders may be distinguished from OCD on a conceptual level. They suggest that thoughts regarding food

or weight gain in the eating disorders are not ego-dystonic and the behaviours are selectively purposeful (i.e. to lose weight or avoid gaining weight), rather than simply anxiety-reducing (see further, Andrews et al., 1994).

OCD AND DEPRESSION

There is no doubt that there is an overlap between OCD and depressive rumination (Rachman & Hodgson, 1980). First, there are certain abnormalities that are sometimes common to both, e.g. sleep disturbance, anxiety and guilt (Edelmann, 1992). Second, 17–70% of OCD patients are typically depressed (Miguel et al., 1997). As a result, the high co-morbidity of OCD with depression often renders differential diagnosis difficult. (Edelmann, 1992; Freeman, 1992; Rachman & Hodgson, 1980). Riggs & Foa (1993) attempted to draw a distinction between depressive rumination and obsessions. First, they argued that, as in GAD, depressive individuals ruminate about everyday, real-life events whereas obsessive-compulsive individuals will tend to have obsessions about unusual and clearly defined topics (e.g. contamination concerns, aggressive thoughts, sexual thoughts). However, as outlined previously in this chapter, a distinction between disorders on the basis of content of thought may be insufficient. Miguel et al. (1997) propose a somewhat clearer distinction. First, they note that obsessive thoughts tend to centre around a current or future event, whereas depressive rumination typically involves a past incident. Second, obsessive compulsive individuals often describe their thoughts as intrusive, senseless and unwanted, and often report an attempt to resist them. In direct contrast, depressive ruminators maintain that their thoughts are non-intrusive and are rarely resisted. Third, OCD thoughts typically (although not always) engender anxiety, whereas depressive rumination produces dysphoria. Thus, despite some overlapping features, there are several reasons to identify OCD and depressive rumination as separate entities (see Chapter 5 for further discussion of this distinction).

OCD AND OBSESSIVE-COMPULSIVE PERSONALITY DISORDER (OCPD)

The essential feature of OCPD is a preoccupation with orderliness, perfectionism and mental and interpersonal control. The relationship between this disorder and OCD has been the subject of a great deal of discussion for some time. As noted previously, as early as the beginning of the twentieth century, Janet (1904) had proposed the notion of the obsessive

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personality: an individual described as rigid, inflexible, overconscientious and persistent (Salzman & Thaler, 1981). Freud (1908) went on to suggest that this characterisation (which he labelled the 'anal-erotic' character), predisposed an individual towards the development of OCD. As such, it would be assumed that OCD would be more aligned to OCPD than any of the other personality disorders. An investigation of this question was conducted by Gibbs & Oltmanns (1995). Using a non-clinical sample of individuals exhibiting obsessive-compulsive symptomatology, these researchers found an association between checking behaviour and OCPD traits, suggesting that there may be a relationship between the checking subtype of OCD and OCPD phenomenology. Certainly the clinical descriptions of OC checkers and individuals with OCPD provided by Nestadt et al. (1991) suggest that they share a common theme, focusing on future orientation.

However, some studies have found that relatively few OCD patients have symptoms of OCPD. Perhaps surprisingly, avoidant personality disorder, dependent personality disorder, histrionic personality disorder, and paranoid personality disorder have been found to be more frequently present than OCPD in some groups of OCD subjects. Further, it should not be forgotten that true obsessions and compulsions are not found in OCPD. Patients with OCPD do not have obsessive-compulsive activity that interferes with their lives to the extent that OCD does (see further discussion in Jenike, 1991). As a number of researchers have pointed out, OCD symptoms are ego-dystonic, whereas OCPD traits are ego-syntonic and do not involve a sense of compulsion that must be resisted (Miguel et al., 1997; Rasmussen & Eisen, 1992). Finally, Jenike (1991) argues that the two disorders respond differently to standard treatments; for example, there is little research showing that behaviour therapy alone is effective in alleviating the symptoms of OCPD.

OCD AND THE PSYCHOTIC DISORDERS

The earliest clinical literature generally made no distinction between OCD and schizophrenia. Nineteenth century accounts suggested that OCD was a variant of schizophrenia, and it was classified at the time within the spectrum of psychoses. Westphal (1878) argued that OCD and schizophrenia shared a number of features, including a similar age of onset, a reduced rate of marriage and fertility, an increased incidence of other disorders, and a poor response to psychological and somatic treatments (Enright & Beech, 1997). Over time, as previously described, OCD came to be regarded

as a neurotic disorder, given the absence of irrational beliefs in line with delusional states. However, more recently it has been argued that not all patients with OCD display rational belief systems with regard to their obsessions. As previously suggested in this chapter, the introduction of the 'poor insight' category in DSM-IV (APA, 1994) somewhat clouds the distinction between OCD and psychosis. How are we able to distinguish between overvalued ideas, poor insight and delusions?

De Silva & Rachman (1992) have attempted to differentiate these phenomena. They argue that, despite the strength of 'overvalued ideas' or delusion-like beliefs exhibited in a minority of OCD cases, 'many of these patients can ultimately be persuaded to concede that they may be mistaken' (p. 22). Of course, this argument is problematic for the many remaining patients who do not make such concessions. Other theorists point to the additional features typically found in the psychotic disorders as a means of differentiating them from OCD. Riggs & Foa (1993) propose that although some individuals with OCD may share a similar degree of poor insight with the schizophrenic constellation of disorders, they may be distinguished by the absence of hallucinations, flat or inappropriate affect and thought insertions that are exclusive to psychotic conditions. Further, it is important to remember that nothing precludes a dual diagnosis of OCD and schizophrenia if an individual does indeed display clear features of both disorders. Indeed, Enright & Beech (1997) have concluded that, although such a comorbidity is infrequent, this dual diagnosis is a powerful predictor of poor prognosis.

A number of studies have been conducted in order to investigate the proposition that some of the processes that underlie schizophrenia may also be evident in OCD. Enright & Beech (1990) demonstrated that OCD subjects exhibit significantly greater schizophrenic-like (schizotypal) features than subjects with other anxiety disorders (see also Chapter 12). Norman et al. (1996) investigated the relationship between OC symptomatology to anxiety and schizotypy in a clinical population of 117 psychiatric outpatients. The results revealed a higher correlation for OCD with schizotypy ($r = 0.60$, $p < 0.001$) than with anxiety ($r = 0.42$, $p < 0.001$). In addition, results from laboratory studies of information processing suggest that OCD subjects exhibit differential effects of negative priming that are more similar to those found in schizotypal and schizophrenic subjects than in the other anxiety disorders (Enright & Beech, 1997). The implication of all of these findings is that schizotypal, schizophrenic and OCD subjects share a common global deficit of cognitive inhibition that may not be evident in any of the other anxiety disorders. Further research on these issues is clearly warranted.

SHOULD OCD BE CLASSIFIED AS AN ANXIETY DISORDER AT ALL?

Ever since the introduction of the DSM-III (APA, 1980), OCD has been classified among the anxiety disorders. However, the inclusion of OCD in this category has not been universally accepted. Treatment failures, inadequate theoretical models, complex association with other disorders and clinical intuition have led many to suggest that OCD must be considered a distinct disorder, qualitatively different from other anxiety disorders (Edelmann, 1992; Enright & Beech, 1990). However, despite these arguments (and the research findings described above), it must still be recognised that anxiety is the most notable presenting symptom of OCD. Individuals suffering with OCD, like the other anxiety disorders, experience fear in the presence of specific stimuli and make efforts to avoid these stimuli. Moreover, little difference has been found between OCD and other anxiety disorders on measures of neuroticism and general measures of trait anxiety or specific fears (Steketee et al., 1987). It is the present authors' view that, in the absence of more compelling data to the contrary, and within the general framework of current classificatory systems, OCD is still best considered an anxiety disorder.

OCD: ONE DISORDER OR MANY?

Ever since its introduction in the DSM (APA, 1952), OCD has been regarded as an homogeneous disorder. Over the last few decades, however, attempts have been made to identify subtypes within the broad domain of OCD (Rasmussen & Eisen, 1992; Summerfeldt et al., 1999). Researchers have endeavoured to classify OCD into groups based on their demographics, phenomenology and symptomatology. One broad approach is the classic distinction between obsessions and compulsions. For example, the ICD-10 (WHO, 1992) has divided this disorder into three main categories as follows: (a) predominant obsessional thoughts or ruminations; (b) predominant compulsive acts (obsessional rituals); and (c) mixed obsessional thoughts and acts. These distinctions, although important, do nothing to classify the types of obsessions or compulsions seen across the many manifestations of the disorder. Given the diversity of presentations of OCD, considerable attention has recently arisen in more multidimensional representations (Summerfeldt et al., 1999). The most common approach appears to be the classification into subtypes based on manifest symptoms, such as washing/cleaning concerns, checking rituals, compulsive hoarding and so on (see Chapter 2).

Reflecting this move to symptom-based subtyping of OCD, prevailing assessment measures for the disorder are divided into subgroups based on presenting symptomatology (see Chapter 14 for a comprehensive discussion of OCD assessment measures). The Maudsley Obsessional Compulsive Inventory (MOCI; Hodgson & Rachman, 1977), for example, is able to determine a total score for OCD symptomatology, as well as scores on the subscales washing, checking, slowness and doubting. The Padua Inventory (PI; Sanavio, 1988) describes common obsessional and compulsive behaviour and identifies four factors underlying OCD: impaired control of mental activities, becoming contaminated, checking behaviours, and urges and worries of losing control over motor behaviours. The Y-BOCS (Goodman et al., 1989b), perhaps the most widely used instrument in the assessment of OCD, is essentially a symptom checklist of an individual's obsessions and compulsions, which is divided into categories based on the content of the obsession/compulsion. These scales suggest that distinct categories exist within the domain of OCD, although these categories have generally been identified *a priori*, rather than on the basis of factor analytic/statistical approaches.

The identification of these categories within OCD might suggest that different theoretical models (or, at least, differing cognitive constructs) may underpin these various subtypes. For example, it has been shown that an expectancy of threat or danger (in the form of disease) appears to drive washing behaviour (Jones & Menzies, 1997a), whereas perceived responsibility (and other constructs) appear more important in the mediation of compulsive checking behaviour (Lopatka & Rachman, 1995; Overton & Menzies, 2001; Salkovskis et al., 1999). These theoretical differences have direct implications for treatment; for example, simply targeting threat expectancy seems sufficient to eliminate compulsive washing (Jones & Menzies, 1997b, 1998a; Krochmalik et al., 2001) but might not be viable as a comprehensive treatment for other subtypes.

EPIDEMIOLOGY

Estimations of the prevalence and incidence of OCD have been subject to considerable scrutiny in recent years. The earliest attempts at estimating prevalence rates for OCD date back to the early 1950s, when Rudin proposed that 0.05% of the general population suffered from the condition. Similar retrospective 'chart review' studies over the next two decades lent support to the impression that OCD was a relatively rare disorder (Black, 1974). It is important to note that these studies were based on clinical

judgements of the percentage of inpatients who presented for treatment, and did not attempt to include any formal diagnostic measures. It was not until the 1980s that any studies using semi-structured interviews to estimate OCD prevalence rates were mounted.

The Epidemiological Catchment Area (ECA) program was undertaken in the early 1980s in an attempt to investigate the epidemiology of prevailing psychopathology in five communities in the USA. The aims of this project were two-fold: (a) to determine the lifetime and 6 month prevalence of OCD in the general population by randomly surveying over 30,000 people, and (b) to determine where patients sought treatment (Rasmussen & Eisen 1992). Lay interviewers were trained in the administration of the Diagnostic Interview Schedule (DIS), an instrument constructed to make DSM-III (APA, 1980) diagnoses.

Results from the ECA study suggested that OCD was more common than earlier reports indicated. The most surprising finding, however, was that lifetime prevalence rates for OCD ranged from 1.9% to 3.3% (Karno et al., 1988), making it 40–70 times as common as hitherto thought. Furthermore, it suggested that OCD was twice as common as schizophrenia or panic disorder. In fact OCD was found to be the fourth most common psychiatric disorder in the US population (Pigott, 1998).

A similar epidemiological study of 3258 randomly selected household residents using the same diagnostic instrument and methodology as the ECA study was conducted in Edmonton, Canada. The results from the ECA study in the USA were supported. Bland et al. (1988) found that the lifetime prevalence of OCD in the Canadian cohort was 3.0%, consistent with the findings from the ECA survey.

Given that these findings represent a major change in the estimated prevalence of OCD, it is important to ascertain whether they are replicable, particularly across cultural boundaries. The Cross-National OCD Collaborative Group study (CNCG study) (Weissman et al., 1994) assessed and compared the prevalence of OCD in six countries: Canada, Germany, Korea, New Zealand, Puerto Rico and Taiwan. Results revealed comparable prevalence rates of OCD as those from the ECA study in the USA. Taiwan was the only country to exhibit a substantially lower prevalence rate of OCD; however, this is consistent with the surprisingly low prevalence rates of other psychiatric disorders that were reported in the same research in this country (Pigott, 1998).

Why are the prevalence rates from these large-scale epidemiological studies so much higher than those in earlier reports? A number of reasons for the discrepancies have been suggested. First, as stated previously, early

estimates were based on clinical judgements alone and neglected the use of diagnostic instruments to estimate prevalence. Given the inadequate level of knowledge about OCD at this time, it is not surprising that clinicians did not routinely consider a diagnosis of OCD when assessing their patients. In addition, with less community understanding of the condition in the past (and potentially greater social stigma), many individuals may have chosen to hide their disorder, lowering the number of presenting individuals with the condition. Further, it must be remembered that, until recently, OCD was considered a purely medical disorder, generally treated within a drug-based framework. There is no doubt that at least some sufferers sought help from relatives, friends, healers and priests, rather than requesting drug-based assistance from medical practitioners. This would further lower presenting patient numbers and affect early prevalence estimates.

Of course, just as it is possible that earlier studies tended to under-report the number of individuals suffering from OCD, it may also be the case that contemporary studies have tended to over-diagnose the condition. Given the level of interest in OCD, the number of available treatments for the disorder and current media attention, contemporary prevalence rates may reflect a bias towards over-reporting. Clinicians may over-diagnose the condition, at least in part, because individuals are now more likely to self-diagnose the disorder. In addition, given the difficulties with respect to differential diagnosis already described, there remains the possibility that the current estimates are an exaggeration of the true prevalence of the condition due to mistaken classification of other disorders as OCD.

Further, despite the fact that the more recent epidemiological studies represent a major advance in research design (compared to studies of the 1950s), a number of criticisms have also been raised about the large-scale population-based studies described above. First, the use of lay interviewers rather than trained clinicians to administer the DIS has been criticised. According to opponents of the ECA study, lay interviewers are likely to over-diagnose all disorders. Some evidence that this may have occurred comes from a series of follow-up studies that used semi-structured interviews administered by psychiatrists. The results suggested a lower OCD prevalence than was suggested in the earlier ECA study (see further, Antony et al., 1998a). Over a decade later, a similar large-scale epidemiological study was conducted in Canada. Not surprisingly, given that this study once again employed lay interviewers to administer the DIS, the results obtained were similar to the pioneering, large-scale epidemiological studies conducted in the 1980s (Stein et al., 1997b).

Second, the use of the DIS itself has been criticised. Antony et al. (1998a) have argued that the DIS: (a) is neither a reliable nor a valid method of

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diagnosing OCD, and (b) leads to a general over-diagnosis of anxiety disorders. Nelson & Rice (1997) conducted a study in order to assess the stability of the diagnosis of OCD in the ECA study. Their results concluded that the DIS diagnosis of OCD possessed extremely limited validity and temporal stability, leaving the true incidence and prevalence of the disorder unknown. However, as Nestadt et al. (1998) have pointed out, the instability of DIS/DSM-III (APA, 1980) OCD diagnoses may be the result of a number of possible factors. These may include reduced recall of symptoms, decreased relevance of symptoms to patients whose symptoms change over time, and the reluctance of patients to admit potentially embarrassing symptoms.

In sum, it must be acknowledged that current estimates may, in the fullness of time, be shown to overstate the community OCD prevalence rate. However, when taken together, it seems safe to suggest that recent findings show the prevalence of OCD to be considerably higher than once assumed. When these epidemiological studies are further replicated, with contemporary diagnostic criteria and better-trained interviewers, more definitive conclusions will be possible (see Chapter 6 for further discussion of the problems of current epidemiological research and their relevance to interpreting available familial/genetic studies).

CONCLUDING COMMENTS

OCD is best conceived of as an anxiety disorder and is currently classified as such, despite the continuing debate over its differential diagnosis. It consists of obsessions, defined as intrusive recurrent thoughts or images that cause a significant degree of distress to the individual, and compulsions, overt or covert rituals that alleviate the associated anxiety that is generated from obsessive activity. Although once believed to be extremely rare, the general consensus is that a relatively high rate (2–3%) of OCD exists in the community. While once in the religious domain, OCD has moved from the psychiatric, medical/structural to the psychological field of investigation, where most modern advances continue to be made.