# Psychopathology of obsessive–compulsive disorder

David Veale

Obsessive–compulsive disorder (OCD) is characterized by the presence of either obsessions or compulsions, but commonly both. To make the diagnosis in ICD-10, either obsessions or compulsions must be present on most days for at least 2 weeks (DSM-IV is broadly similar in its definition of OCD). Furthermore, the obsessions or compulsions must cause significant distress or interfere with the patient's social or individual functioning, usually by wasting time. Obsessions or compulsions can occur in the context of other disorders such as schizophrenia, depression and Tourette's syndrome. This contribution discusses each of the main areas of psychopathology of OCD, namely obsessions, emotions, compulsions, avoidance and safety-seeking behaviours, and then briefly covers the nature of the handicap, family involvement and epidemiology.

## Obsessions

An obsession is defined as an unwanted intrusive thought, image or urge that repeatedly enters the person's mind. Obsessions are distressing and ego-dystonic (i.e. the self views the thoughts or behaviours as repugnant or inconsistent with his or her personality) but are acknowledged as originating in the person's mind and not imposed by outside agency. They are usually regarded by the individual as unreasonable or excessive. A minority are regarded as over-valued ideas (Veale, 2002) and, rarely, delusions. The sufferer usually tries to resist them, but in chronic cases this may be to a very minor degree or not at all. The most common obsessions are listed in Figure 1.

Religious obsessions used to be very common but are now less frequent in Western cultures. However, contemporary fears such as catching HIV and being responsible for child abuse are increasingly reflected. Unwanted intrusive thoughts, images or urges are almost universal in the general population and their content is indistinguishable from clinical obsessions (Rachman and de Silva, 1978). Examples include having the urge to push someone on to the tracks in the Underground, or a thought that the cooker has been left on. The difference between a normal intrusive thought and an obsessional thought is the meaning that OCD patients attach to the occurrence and/or content of the intrusions. One of the core appraisals in OCD is an over-inflated sense of responsibility for harm or its prevention. Responsibility is defined here as:

> '*The belief that one has power that is pivotal to bring about or prevent subjectively crucial negative outcomes. These outcomes may be actual, that is having consequences in the real world, and/or at a moral level*' (Salkovskis *et al.*, 1995).

The difference in OCD is the appraisal that harm might occur to the person, a loved one, or another vulnerable person through what the person might do or fail to do. 'Harm' is interpreted in the broadest sense and includes mental suffering; for example, some people with OCD find it difficult to articulate the meaning of their obsession: they just feel very anxious and might believe that they will go crazy or that the anxiety will go on for ever. Individuals with OCD believe they can and should prevent harm from occurring, which leads to the compulsions and avoidance behaviours.

OCD patients have a number of other cognitive biases that are not necessarily specific to OCD but, in combination with an inflated sense of responsibility, lead to anxiety and compulsive symptoms. These biases include:

- an over-estimation of the likelihood of harm occurring
- a belief about being more vulnerable to danger
- an intolerance of uncertainty, ambiguity and change
- the need for control.

In some patients, the need for perfectionism and excessive concern over mistakes are especially relevant. Such patients tend to believe that there is a perfect solution to doing anything.

### Obsessions and emotion

The emotional consequences of an obsession are difficult for some patients to articulate and are often described as 'discomfort'

### Common obsessions in OCD[1]

- Contamination from dirt, germs, viruses (e.g. HIV), bodily fluids or faeces, chemicals, sticky substances, dangerous material (e.g. asbestos) (37.8%)
- Fear of harm (e.g. door locks are not safe) (23.6%)
- Excessive concern with order or symmetry (10%)
- Obsessions with the body or physical symptoms (7.2%)
- Religious, sacrilegious or blasphemous thoughts (5.9%)
- Sexual thoughts (e.g. being a paedophile or a homosexual) (5.5%)
- Urge to hoard useless or worn-out possessions (4.8%)
- Thoughts of violence or aggression (e.g. stabbing one's baby) (4.3%).

[1]Percentages refer to the frequency in a survey of 431 individuals with OCD (Foa *et al.*, 1995)

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or distress. Clinical assessment involves trying to unravel the most dominant emotions and linking them with the appraisal. Commonly, people with OCD believe they might be responsible for preventing harm or catastrophe in the future, and the main emotion is of anxiety. An example is an OCD patient who thinks he might have left on an electric appliance and that this might lead to a fire. Some sufferers experience an additional emotion of disgust especially when they think they could have been in touch with a perceived contaminant such as faeces. Others feel ashamed and condemn themselves for having intrusive thoughts of, for example, a sexual or aggressive nature, which they believe they should not have. Occasionally, a person with OCD believes he may be responsible for a catastrophic event in the past; in such cases, the main emotional consequence is of guilt. Many individuals are also depressed with various secondary problems caused by the handicap; comorbidity with a mood disorder is relatively common. At times, anger and irritability are prominent and seriously affect their relationships. Because of the range of emotions, it is not surprising that some patients find it difficult to articulate and untangle their dominant emotion.

## Compulsions and safety-seeking behaviours

Compulsions are repetitive behaviours or mental acts that the person feels driven to perform. A compulsion can either be overt and observed by others (e.g. checking that a door is locked) or a covert mental act that cannot be observed (e.g. repeating a certain phrase in one's mind). Covert compulsions are generally more difficult to resist or monitor than overt ones as they are 'portable' and easier to perform. A compulsion is not in itself pleasurable, which differentiates it from impulsive acts such as shopping or skin-picking that are associated with immediate gratification. The term 'ritual' is synonymous with compulsion but usually refers to motor acts. 'Rumination' usually covers both the obsession and any accompanying mental compulsions and acts. As with obsessions, there are many types of compulsion: the most common are listed in Figure 2.

### The purpose of compulsions

The early experimental studies of Rachman and Hodgson (1980) established that compulsions, especially cleaning, are reinforcing because they seem to work and reduce discomfort in the short term. This increases the urge to perform the compulsion again, and a vicious circle is thus maintained. Checking compulsions had a similar function to cleaning but tended to be slightly less successful at reducing discomfort. However, compulsions do not always work by reducing anxiety and are often intermittently reinforcing.

Alternatively, compulsions may function as a means of avoiding discomfort, as in examples of obsessional slowness (Veale, 1993). Compulsions for hoarding refer to the acquisition of and failure to discard possessions which appear to be useless or of limited value, and to cluttered living spaces that prevent appropriate use of the space (Frost and Hartl, 1996).

### Neutralizing and safety-seeking behaviours

Neutralizing resembles a mental compulsion but is not identical, although both usually serve to reduce anxiety. Neutralizing is not necessarily stereotypic or a compulsive urge but has the aim of undoing the perceived harm. By comparison, compulsions are

**Common compulsions in OCD[1]**

- Checking (e.g. gas taps) (28.8%)
- Cleaning/washing (26.5%)
- Repeating acts (11.1%)
- Mental compulsions (e.g. special words or prayers repeated in a set manner) (10.9%)
- Ordering, symmetry or exactness (5.9%)
- Hoarding/collecting (3.5%)
- Counting (2.1%)

[1]Percentages refer to the frequency in a survey of 431 individuals with OCD (Foa et al., 1995)

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largely involuntary and repetitive and are seldom resisted. The term 'safety-seeking behaviours' is also used to refer to any actions in a feared situation that aim to prevent feared catastrophes and reduce harm (Salkovskis, 1985) and therefore includes compulsions and neutralizing behaviours. Examples of other safety-seeking behaviours include mental activities such as trying to be sure of the accuracy of one's memory; or trying to suppress or distract oneself from unacceptable thoughts – this may reduce anxiety in the short term but leads to a paradoxical enhancement of the frequency of the thought in a rebound manner.

The aim of a compulsion or neutralizing behaviour is thus to reduce harm and feel 'comfortable' or 'just right', and is an additional criterion used for terminating a compulsion. Someone without OCD finishes hand-washing when they can see that their hands are clean; someone with OCD and a fear of contamination finishes not when they can see that their hands are clean but when they feel 'comfortable' or 'just right'.

## Avoidance behaviours

Although avoidance is not part of the definition of OCD, it is an integral part of the disorder and is most commonly seen in fears of contamination. An example of avoidance is a woman with a fear of contamination from dirt who would not touch toilet seats, door handles or taps used by others. She would hover over the toilet seat; kick open doors or use her elbow to open doors and taps; use rubber gloves to put rubbish in the dustbin; and avoid picking up items from the floor, shaking hands with people or touching any substance that looked dangerous to her.

Not all situations can be avoided and safety-seeking behaviours are often used within a feared situation. Clinical assessment (see Figure 3) requires a rating of predicted distress so that a hierarchy of avoided situations without safety-seeking behaviours may be included in therapy, together with an understanding of how they interact with the obsessions and the distress experienced.

## Linking obsessions, compulsions and avoidance behaviour

The content of the obsessions, compulsions and avoidance behaviour are closely related. For example, when a patient has to touch something that he or she normally avoids, then the compulsive

### Clinical assessment of OCD

**Clinical assessment should cover the following areas:**

- The nature of the obsession(s), which involves determining:
  i) their content
  ii) the degree of insight or overvalued ideation
  iii) the frequency of their occurrence
  iv) the triggers
  v) the appraisal of the obsessions and the patient's understanding for their frequent occurrence
- The main emotion(s) that links with the obsession
- The compulsion(s), which requires determining:
  i) their content
  ii) a rating of predicted distress if the compulsion or neutralizing was resisted
  iii) the feared consequences of resisting the compulsion or neutralizing
  iv) the criteria used for terminating the compulsion
  *Indirect assessment* might include activities such as the number of rolls of toilet paper or bars of soap used per day or per week
- The avoidance behaviour, which requires a list of all the situations or activities avoided and rated on a scale (for example, from 0–100 in standard units of distress (SUDs), according to how much distress the person will anticipate if he or she confronts the situation without a safety-seeking behaviour
- The degree of family involvement
- The degree of handicap in the person's occupational, social and family life

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### Making the links with phenomenology in OCD

- **Trigger:** visiting mother dying from cancer
- **Obsession:** intrusive thoughts and images or oral sex with one's mother
- **Appraisal:** I could act on the thought. I must be the lowest form of life to even think of such an act with my mother who is dying
- **Emotion:** shame and anxiety
- **Compulsions:** saying a prayer repeatedly until I feel comfortable
- **Neutralizing and safety behaviour:** try to alter the image so that mother is eating a banana
- **Avoidance:** avoid being near my mother and make excuses about not visiting
- **Secondary appraisals and emotions of guilt** for avoiding my mother when she is dying, and dealing with anger by rest of the family

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washing starts. When avoidance is high, the frequency of compulsions may be low, and vice versa. If a woman's obsession is of stabbing her baby, she might avoid being alone with her baby and put all knives or sharp objects out of sight, 'just in case' she has the urge to harm her baby. When this does not work, she may ensure that someone is with her all the time (a safety-seeking behaviour), or try to neutralize the thought in her head. These acts in turn increase her doubts and prevent her from disconfirming her fears, and the vicious circle continues. Another example linking the phenomenology is shown in Figure 4.

## Family involvement

Assessment needs to focus on the degree of family involvement in assisting in the avoidance or compulsions and their attitudes to treatment. Other members of the family may be restricted in their activities (like using the bathroom) or may not be able to use certain rooms in the home because of hoarding. In general, families may either accommodate the individual's OCD or be over-protective, be aggressive, or not engage with the person's obsessions. The individual with OCD may also react with aggression when their compulsions are not adhered to by the family. Frequently, different members of the family use different ways of coping and further discord will ensue between family members. Finally, the family may seek help for their relative, but the relative may be unwilling to seek help him/herself.

## The handicap of OCD

The severity of OCD differs markedly from one person to another. Individuals may be able to hide their OCD, often from their own families. However, OCD often causes havoc in relationships, leading to frequent marital discord, separation and divorce. OCD often interferes with a person's ability to study or work, either making it impossible or creating significant disadvantages. OCD is ranked by the World Health Organization as one of the 10 most handicapping illnesses by lost income and decreased quality of life.

## Assessment scales

A discussion of suitable assessment measures (both self-report and observer) may be found in the suggestions for further reading. The Yale-Brown Obsessive-Compulsive Scale (YBOCS) is the most commonly used observer-rated outcome measure (Goodman *et al.*, 1989). It has a checklist which is helpful in making a list of the various obsessions and compulsions and defining the severity of the symptoms. This may assist in defining problems and goals for treatment. The Obsessive-Compulsive Inventory (Foa *et al.*, 1998) is a good self-rated inventory that is useful for the assessment of symptoms and as an outcome measure.

## Epidemiology

**Prevalence:** OCD is more common than was previously thought. It is the fourth most common mental disorder after depression, alcohol/substance abuse and social phobia, with a lifetime prevalence in community surveys of about 2% (although the instruments used may have over-diagnosed OCD). One reason why the level

of OCD has been underestimated in the past is that sufferers are often ashamed to seek help.

**Sex ratio:** this is equal, but more women than men suffer from compulsive washing, and more men have obsessions about sex or numbers or have obsessional slowness.

**Age of onset:** the mean age of onset is late adolescence for men and the early 20s for women. However, it may take individuals 10–15 years to seek professional help. Children and adolescents also suffer from OCD. The disorder in children is much the same as in adults, although they often find it difficult to articulate the meaning of their obsession or the feared consequences of not carrying out their compulsion (for more details of OCD in children and adolescents, see the contribution by Maskey in *PSYCHIATRY* 2002; **1:7:** 86–90). ◆

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## FURTHER READING


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