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Obsessive–compulsive disorder: what is it?

Key points

- Obsessive–compulsive disorders are psychological disorders.
- The most common features are obsessions and compulsive behaviour.
- Obsessions are defined and described.
- Compulsive behaviour is defined and described.
- A diagnosis of obsessive–compulsive disorder is made on the basis of the person's complaints, detailed interviews, and psychological tests.
- It is customary to classify the disorders into mild, moderate, and severe cases.
- In severe cases the patient experiences considerable distress and disability.
- Obsessive–compulsive disorders develop in late adolescence or early adulthood.
- Approximately 1.6% of the population develop the disorder.

Obsessive–compulsive disorder has been traditionally regarded as a neurotic disorder, like phobias and anxiety states. Other terms used for this disorder include: 'obsessive (or obsessional)–compulsive neurosis' and 'obsessive (or obsessional)–compulsive illness'—or simply 'obsessive (or obsessional) disorder' or 'compulsive disorder'. It can interfere with one's life, and people with this problem suffer considerable distress, and often feel that they are helpless and hopeless. They are afflicted with disturbing unwanted thoughts and feel

compelled repeatedly to carry out activities that they know to be irrational. It is difficult for them to understand, and equally difficult to explain to other people, why they repeatedly engage in senseless behaviour. The fact that their obsessive–compulsive problems are so puzzling as to defy explanation is an added burden, and can erode one's self-esteem. Neurotic disorders are generally considered to be less handicapping and disabling than psychotic illnesses—such as schizophrenia—but severe obsessive–compulsive disorder can cause great distress and major incapacitation.

Patients who suffer from anxiety disorders, such as obsessive–compulsive disorder, are aware that they have a psychological problem that leads them to think and behave irrationally in particular circumstances. In all other respects their intellectual abilities and ability to reason are unimpaired. Most sufferers are able to function at least moderately well: they are able to work, maintain family and other relationships, and pursue their goals and interests. In contrast, most people afflicted with major mental illnesses, psychotic disorders, such as schizophrenia, suffer from numerous and chronic impairments. Many of them have limited insight into what is wrong, and their contact with the outside world may be seriously distorted. Their relationships with other people tend to be unsatisfying and unsatisfactory.

The terms 'neurotic disorders' and 'neuroses' are not widely used any more, and have been replaced by the term 'anxiety disorders'. Obsessive–compulsive disorder is now classified as one of these anxiety disorders. Other disorders that are included are: phobias, panic disorder, post-traumatic stress disorders, social phobias, agoraphobia, and generalized anxiety stress disorder. Intense and poorly controlled anxiety is the basic feature of these disorders, and there is overlap of symptoms among them. The types of anxiety disorder are set out in Table 1.1.

Table 1.1 Anxiety disorders

Anxiety disorders
Panic disorder, with or without agoraphobia
Agoraphobia, without a history of panics
Social phobia
Specific phobia
Generalized anxiety disorder
Obsessive–compulsive disorder
Post-traumatic stress disorder
Acute stress disorder

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Table 1.2 Summary of criteria widely used for the diagnosis of obsessive–compulsive disorder

1. The person must have either obsessions or compulsions or both. (a) *Obsessions* are recurrent, persistent ideas, thoughts, images, or impulses that intrude into consciousness and are experienced as senseless or repugnant. They form against one's will, and the person usually attempts to resist them, or get rid of them. The person recognizes that they are his own thoughts. They also cause marked anxiety or distress. (b) *Compulsions* are repetitive, purposeful forms of behaviour that are carried out because of a strong feeling of compulsion to do so. The goal is to prevent or reduce anxiety or distress, or to prevent some dreaded event or situation. However, the activity is not connected in a realistic way with what it is aimed to prevent, or it is clearly excessive. The person generally recognizes the senselessness of the behaviour and does not get pleasure from carrying out the activity, although it provides a relief from tension. Compulsions are usually performed according to certain rules or in a stereotyped fashion.
2. They are not due to another disorder, such as schizophrenia, depression or organic mental disorder.
3. The obsessions and/or compulsions cause distress to the person and/or interfere with his life and activities.

What is meant when someone is described as having an obsessive–compulsive disorder? The person displays and/or complains of either obsessions or compulsions or both, to a degree that affects his everyday functioning or causes him distress. Diagnosis of the condition is made on this basis (Table 1.2).

What are obsessions?

An obsession is a recurrent, unwanted, intrusive, unacceptable, and persistent thought, image, or impulse. Obsessions are not voluntarily produced, but are experienced as events that interrupt one's attention. The affected person recognizes that these thoughts are his own, and are not introduced or controlled by some outer force or other person. This is an important feature since, in certain mental illnesses, patients may feel that thoughts have been inserted into their heads by other people, outside agents, or even by the radio or TV. Obsessions are not experienced in this way. The thoughts can be repugnant, blasphemous, obscene, worrying, nonsensical, or all of these. The person neither wants nor welcomes them; instead, he resists them and tries to get rid of them. They are characteristically difficult to block or suppress, and at times the sufferer feels besieged by them (the word 'obsession' is derived from the Latin '*obsidere*', to be besieged). They are intrusive as well as tenacious. The person may be engaged in some activity, such as driving a car or trying to

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study, when the obsession intrudes into his consciousness. It interrupts his ordinary, preferred thinking and behaviour.

Virtually all obsessions clash with the person's important values and are unacceptable, shameful, repugnant, and upsetting. They give rise to painful self-doubting.

Some examples of obsessions are as follows:

- A 25-year-old woman had recurrent intrusive impulses to strangle domestic animals. They were followed by the thought or doubt that she might actually have done so.
- A woman had recurrent intrusive thoughts that she was contaminated by dirt and germs from strangers or, worse, that she was inadvertently contaminating other people.
- A man had recurrent intrusive doubts that he might have driven into a pedestrian, and often felt compelled to retrace his journey to check.
- A trainee nurse was tormented by recurrent thoughts that she might lose control one day and sexually molest a child.
- A young man had the recurrent intrusive thought 'Christ was a bastard'. He also felt an impulse to shout this out during a church service.
- A woman had the recurrent intrusive thought that she might offend people by touching them in a sexual, inappropriate manner.
- An engineer had recurrent intrusive images of himself violently attacking his parents with a kitchen knife. The obsession included images of the victims, of blood flowing, and of injuries caused.
- A woman had recurrent, intrusive impulses to harm herself by damaging her eyes. They were accompanied by vivid images of the act.
- A 14-year-old girl had recurrent impulses to blurt out nasty obscenities in public. She had tormenting doubts about whether or not she had already done so.
- An occupational therapist had recurrent thoughts that she might harm cyclists by pushing them into busy traffic.

Obsessions occur in one of three forms: a thought, an image, or an impulse, or a combination of these. When the obsession intrudes, the person usually

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resists it. Even if he succeeds in blocking it, it is likely to return within a short period of time. Some patients report that their obsessions are with them most of their waking hours, despite desperate struggles to get rid of them. The mental effort involved in attempting to subdue obsessions can be exhausting, even though the struggle is not evident to friends and relatives. For some it feels as if the obsession is always there, lurking at the back of their minds.

Obsessions tend to flourish during periods of unoccupied solitude, and are less frequent during pleasant conversations or other engaging activities.

Different uses of the word 'obsession'

The meaning of the technical term 'obsession' in the context of obsessive–compulsive disorder is different from its meaning in day-to-day language. We often hear someone being described as 'obsessional about his job', and expressions such as, 'He is obsessed with her', 'Football is an obsession with him', and so on. What is meant in such instances is that the person in question has an unusually great interest in something or someone, spends a lot of time thinking about it, and can become preoccupied. But such an attachment, interest, or preoccupation is not seen by him as unwanted or unacceptable, and there is no resistance, nor any attempt to block it. These preoccupations are pleasing and welcome, and are promoted unless they occur at inconvenient times. They are very different from the way the clinical, technical term 'obsession' is used in reference to the unwanted and unwelcome intrusive thoughts that occur in obsessive–compulsive disorders.

Features of obsessions

What are the contents of obsessions? There are three common themes, in descending order of frequency: unwanted thoughts of aggression/harm, unwanted sexual thoughts, and blasphemous thoughts. The harm obsessions are the most common, and the blasphemous ones are the least common.

These are examples of obsessions with an aggression/harm theme. The person repeatedly has unwanted, unwelcome thoughts of harming elderly people, say by pushing them in front of oncoming traffic, or of attacking or molesting children. Obsessions often produce a fear of losing control—'What if one day I lose control and attack an elderly person?'. Sexual obsessions often include recurrent images, as well as thoughts of repugnant unacceptable sexual wishes or acts, such as incestuous thoughts, molesting children, and images of sexual exhibitionism. As with the aggressive obsessions, those with sexual content often arouse a fear of losing control, which in turn leads to avoidance of the

people or places that are associated with the obsessions. People who experience recurrent intrusive thoughts of molesting children generally take great care to avoid being alone with a child. Blasphemous obsessions, such as having obscene thoughts about sacred figures or shrines, can be extremely upsetting and give rise to tormenting self-doubt and self-criticism. 'I must be a total hypocrite to have these recurrent thoughts while appearing to be a righteous and religious person.'

It is probable that obsessions develop when the affected person mistakenly attaches great personal significance to the uninvited and repugnant thoughts that virtually everyone experiences from time to time (see pp. 14–15). Whereas most people dismiss these thoughts as nonsensical and insignificant, some extremely sensitive people with highly elevated personal standards regard them as being important. If the affected person interprets the intrusive thoughts as being personally revealing and highly significant, then they tend to recur over and over again.

There is a strong tendency to conceal these recurrent and repugnant thoughts, mainly because the affected person anticipates, usually incorrectly, that if other people learn about these thoughts they too would interpret them as being revealing and highly significant. 'If other people really knew about my ugly thoughts they would recoil and brand me a monster.' One patient described his aggressive and sexual obsessions as 'my ugly little secret'. The mistaken interpretations made by patients who are tormented by obsessions generally lead to one or all of these conclusions about their 'deep, true character'—it means that 'I am mad, bad, or dangerous, or all three of these'.

Senseless and trivial obsessions, such as advertising jingles, are rare but can be a troublesome nuisance. In some cases, the obsession consists of a doubting thought, which can apply to most things that the person does. For example, a young woman complained that, whenever she performed any action, she would immediately be assailed by the thought 'Did I do it right?' or 'Have I done the right thing?'.

Obsessions produce internal resistance, which can take various forms such as trying to block the thought/image/impulse, endlessly debating with oneself, praying repeatedly, trying to neutralize or wipe out the thoughts, or even escaping completely from the situation in which the thought is experienced. Obsessions can also lead the patient to avoid other people.

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Thought–action fusion

In some instances, an intrusive thought becomes significant because of a tendency to regard thoughts as being psychologically equivalent to the corresponding action. Thus, having the thought 'I may strangle someone' is regarded as being as reprehensible as actually strangling a person; there is a moral equivalence. A related tendency is to believe that, because one has had a thought about a misfortune or disaster, the likelihood of that misfortune actually occurring is increased. A university student was extremely disturbed by recurring intrusive images of his parents in a motor vehicle accident because he felt that his images actually increased the probability that they would have an accident. If a patient attaches great significance to this form of 'biased' thinking, termed 'thought–action fusion', he feels responsible for potentially harming someone else, and the ensuing guilt and distress add to his problems.

What are compulsions?

A compulsion is purposeful, meaningful, and deliberate behaviour that the person feels driven to carry out repeatedly, and is usually performed according to certain rules or in a stereotyped fashion. The aim is to prevent harm or misfortunes occurring to oneself or others. For example, a patient attempts to remove some contamination by washing his hands over and over again in order to prevent an illness. Another patient feels compelled to check the safety of the front door a dozen times in order to prevent a burglary. The act is preceded or accompanied by a sense of subjective compulsion—i.e. the person feels a powerful urge to engage in the preventive behaviour. Patients who wash compulsively can damage the skin on their hands, and, in an extreme case, a patient continued washing his hands in hot water despite traces of blood in the wash-basin.

In most instances the person recognizes the senselessness or irrationality of the behaviour. The behaviour is regarded as appropriate but excessive or over-elaborate. There is a desire to bring the checking/washing behaviour down to a realistic level, but the urge repeatedly to do it 'thoroughly' is over-powering. No pleasure is derived from carrying it out, although it can provide a release of tension or a feeling of relief in the short term.

The most common compulsions involve repeated and stereotyped washing or checking:

- A woman repeatedly and extensively washed her hands to get rid of contamination by germs. The washing was done in an elaborate ritual, six times without soap and six times with soap, on each occasion.

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- A young man checked door handles, gas taps, and electric switches every time he went past them.
- An accountant had to check his calculations dozens and dozens of times. As a result he worked 12-hour days but was always behind and had to give up the job.
- A 15-year-old girl cleaned and washed the area around her bed, including the wall, every night before going to bed, in order to rid it of germs and dirt.
- A man opened letters he had written and sealed, to make sure that he had written the correct things. He would rip open the envelope, re-read the letter, and put it into a new one, several times before posting it. A contemporary form of this compulsion is repeatedly checking one's e-mail messages, over and over again, before sending them, or simply deleting them.
- A woman who feared that she might develop cancer checked her body up to 10 times per day.
- A man had the compulsion to touch with the left hand anything he had touched with the right hand, and vice versa.
- A man with an intense fear of dirt felt compelled to shower at least six times per day, always washing his body in the same stereotyped manner.
- A woman had the compulsion to wipe, with a wet cloth, all tables and worktops several times, each time that she was to use them. She did this to get rid of what she called 'invisible food particles'.
- A manager spent at least an hour repeatedly checking all the windows and doors of his store before leaving for home; members of the staff were able to carry out the same procedure in 5 minutes.
- A 35-year-old married woman had the compulsion to wash and disinfect herself and her clothes, out of fear of contracting cancer. She spent many hours each day doing this.

The person feels an irresistible urge—compulsive urge—to engage in a particular behaviour, which he carries out repeatedly despite recognizing that it is irrational or excessive. The avowed purpose is to prevent a misfortune or avoid harm, and the person feels a special responsibility for these preventive acts.

Compulsive cleaning

The driving force behind most cases of compulsive cleaning is an intense fear of contamination. The purpose of the repetitive washing/cleaning is to remove the threat of the perceived contamination.

Feelings of contamination fall into two main categories. In the most common form, the person feels contaminated by physical contact with dangerous, dirty, or disgusting objects or materials (e.g. dirty needles, chemicals, decaying food, urine, faeces). A second type of contamination, mental contamination, can arise from actual or indirect associations with people who are believed to have harmed the patient in some way.

Contamination is an intense, persisting, and unpleasant feeling of having been polluted or infected by physical contact with, or by association with, a place or person that is soiled, impure, infectious—or a combination of these. Contamination is accompanied by unpleasant emotions, among which fear, disgust, guilt, immorality, and shame are prominent. Feelings of contamination instigate vigorous attempts to remove, to clean away, the infectious material, the dirt, the impurity. Intensive, meticulous, repetitive washing and cleaning compulsions are undertaken in an attempt to remove the feeling of dirtiness and protect one's health. As a secondary consequence, it leads to extensive avoidance of situations in which the person fears that there is the possibility of contact with a contaminant. In extreme cases, patients avoid entire 'contaminated' cities. Public washrooms are a great problem; they are perceived to be particularly threatening, and if it is impossible totally to avoid them, then patients adopt a variety of rudimentary protective measures, such as opening the doors with their feet or elbows, using a Kleenex, or walking in behind another person. Some patients feel that their contamination can be transmitted to other people and will go to great lengths to avoid spreading it.

We are all familiar with the feeling of contamination that arises when we touch something dirty or polluted, and we are equally familiar with the resulting urge to wash away the contaminant. In patients with obsessive–compulsive disorder, the sensitivity to actual or perceived contamination is heightened, the feelings are extremely intense, and the anticipated consequences are catastrophic. This is the familiar form of contamination after physical contact with a pollutant. The less familiar form of mental contamination can be equally distressing and damaging but is far less obvious.

Compulsive cleaning is one of the most common, classical, manifestations of obsessive–compulsive disorder.

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Checking compulsions

Checking compulsions are attempts to reduce the probability of some misfortune occurring; patients repeatedly check the safety of electrical appliances, doors, vehicles, and check their work repeatedly if they believe that an error might have serious consequences. The urges to check and re-check are driven by an inflated sense of responsibility for protecting others and oneself from catastrophic errors or carelessness. An experienced pharmacist who worked in a large pharmacy had prepared over 10 000 prescriptions during the past 10 years. He had made only two trivial errors in that period, but every day went to work expecting that he might make a serious error. He estimated that the probability of such an error, every working day, was 100%. He estimated the probability of equally experienced colleagues making an error as 0.001%. He rated his own probable 'error' as totally catastrophic, probably fatal, but a colleague's error as minor. At the same time he felt that he was at least as competent as most of his colleagues, and superior to many of them.

A grossly inflated sense of personal responsibility is present in most cases of compulsive checking and, as illustrated above, is combined with inflated estimates of the probability of making an error and inflated expectations of the seriousness of the feared error. It is not surprising that certain jobs are a trial for patients with a tendency to check repeatedly; they include pharmacy, law, accountancy, medicine, security officers, safety inspectors, and so on.

As with washing compulsions, the affected people feel that their checking behaviour is appropriate but excessive, out of control and damaging. Moreover, even when they have completed their actual checking rituals, they continue to check mentally. They are never off-duty mentally. It is a draining and endlessly frustrating, exhausting problem.

Covert compulsions

Many patients have covert compulsions that have the features of observable compulsions:

- A man had the compulsion to say silently a string of specific 'safe' words whenever he heard or read of any disaster or accident.
- A woman, who was distressed by the recurrent intrusion of unwelcome and obscene words, carried out a compulsion each time this happened. She tried with little success to deal with the obsessions by changing the words into similar but acceptable ones—e.g. 'well' for 'hell'—and saying them silently four times.

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- A middle-aged man had the compulsion to visualize everything that was said to him and could not reply until he had formed these visual images. Often this would take time, leading to long silences that were puzzling to others.

- A woman, who was tormented by intrusive repetitions of bloody images of her relations and friends, felt compelled to re-constitute the images until the people concerned appeared to be in good health. This method of trying to deal with such images, re-animation, is not uncommon among patients suffering from recurrent violent/harmful images.

- A woman became very worried if she set her eyes on black objects, especially if this occurred immediately before retiring to bed. When this happened she had the obsessional thought that it would cause her to go blind, or lead to some other disaster. So every time she experienced the thought, she felt compelled to neutralize the obsession by visualizing an object of a different colour, usually white, as a way of preventing disaster.

- A woman who had the recurrent obsessional thought that she was responsible for any murders that she read or heard about engaged in the compulsion of silently saying 'I did not do it' seven times, each time such a thought came.

The active nature of compulsions

It needs to be stressed that compulsions are actively carried out, and for a recognized purpose. *Compulsions are not mere repetitions*; they are purposeful, meaningful, and deliberate behaviour. The patient is not happy about doing it, but it is a voluntary and controllable action that is performed reluctantly, almost against their wishes. The urges driving the compulsions are strong but the compulsive behaviour can be partly controlled—it can be postponed, it can be lengthened, partly abbreviated, re-shaped, concealed, and, in certain circumstances, it can be carried out for the patient by another person (e.g. checking behaviour). The malleability of the compulsive behaviour is most evident in compulsive checking—it can be lengthened, abbreviated, postponed, often concealed, and so on. Compulsions are driven but they are not totally inflexible, and they are not automatic behaviour. They are different from the tics and muscle spasms that are observed in some people, especially children, which are essentially involuntary, meaningless, purposeless, repetitive motor responses. These are not actively, deliberately carried out by the patient, and are not compulsions.

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Sometimes the mere occurrence of repetitive behaviour is mistaken for the compulsive behaviour seen in obsessive–compulsive disorders. This can be a source of confusion but is easily clarified when a full psychological assessment is carried out.

Resistance

Obsessions and compulsions are generally resisted. For some time it was considered by many experts that resistance is an essential feature of obsessive–compulsive disorders, but there are exceptions. In the majority of cases, the person does resist the obsession or the compulsive urge, especially in the early stages of the disorder. However, after repeated failures effectively to resist the obsessions and compulsions, the person's resistance may wane. Patients with strongly established, chronic obsessive–compulsive problems may report little or no resistance to the obsessions or the compulsive urges because they have yielded to them.

Different uses of the word 'compulsion'

As with the term 'obsession', our use of the clinical, technical term 'compulsion' is different from, and more specific than, the way it is used in everyday language. It is common to hear about 'compulsive lying', 'compulsive eating', 'compulsive gambling', and so on. These types of behaviour are different from the kinds of clinical compulsions that we are concerned with here. As noted, compulsions are repetitive acts that are the result of an urge, which the person usually tries to resist, and which are carried out reluctantly. They are seen as essentially irrational or senseless, and give no pleasure or satisfaction. Forms of behaviour such as compulsive eating and gambling do not show these features—although they are problems in their own right, they are not indicative of an obsessive–compulsive disorder.

Sometimes the term 'compulsive' is used for behaviour such as recurrent nail-biting, thumb-sucking, and hair-pulling. These are habits, and the person usually engages in them, at least part of the time, without being aware of them. They lack the characteristic features of the compulsion in obsessive–compulsive disorder, such as purposefulness and meaningfulness, and certainly cannot be performed for the person by someone else. True compulsions are carried out in order to accomplish some aim; behaviours such as nail-biting, hair-pulling, and so on are not, and nor do they provoke a feeling of resistance. These kinds of behaviour are best seen as habits rather than true compulsions, as their similarity to the latter is superficial.

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Putting matters right

Some instances of compulsive behaviour are attempts to 'put matters right'—for example, to ensure that one's appearance is exactly right, to place one's belongings in a particular place, or ordered in a rigidly prescribed manner:

> A 28-year-old man spent up to 5 hours per day combing and brushing his hair 'to get it right', and felt extremely uncomfortable till he succeeded. Whenever he left his home he wore a cap to conceal his hair, unless it felt perfectly right.

The urge to put matters right is associated with the compulsion to arrange and order one's possessions (books, clothes, papers). This can take many hours and must be satisfactorily completed before leaving or before starting on a fresh task. Intense ordering and arranging is more noticeable in child obsessive–compulsive disorder than in adult cases, perhaps because other, and more severe, compulsions arise in adulthood and overshadow the compulsion to order and arrange. People, young or old, who feel compelled to introduce and maintain inflexible order can react strongly if their 'systems' are disrupted. The drive for order can be associated with the comparable compulsion to introduce symmetry and exact balances, mainly pertaining to one's possessions.

A self-report scale for assessing the compulsions to order, arrange, and ensure symmetry, is reproduced in Appendix 5.

The diagnosis of obsessive–compulsive disorder

A person may be considered to have an obsessive–compulsive disorder if he experiences or displays obsessions or compulsions, or both. However, it is necessary to add an important qualification: it is not merely the presence of obsessions and/or compulsions as such that matters, but the degree to which they cause distress and/or interfere with the person's life. As mentioned earlier, it is customary to grade the seriousness of the disorder, from 'mild' to 'moderate' or 'severe'.

As a result of recent publicity there is a tendency to over-diagnose obsessive–compulsive disorders. For example, in a study carried out in Canada in 1997, clear indications of over-diagnoses were obtained. After a 'screening' for the disorder in a community sample, a full clinical assessment revealed that well over half of the provisional diagnoses of obsessive–compulsive disorder were incorrect. Numbers of people who reported troubling worries or repetitive

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behaviour were initially over-diagnosed, but in the subsequent comprehensive clinical examinations no significant symptoms of obsessive–compulsive disorder were detected. There were many 'false positives'. For this reason it is essential to ensure that the person receives a full and accurate assessment.

Obsessions and compulsions in the general population

It is important to recognize that obsessions and compulsions are not uncommon in the general population. There are many people who have mild versions of obsessions and/or compulsions, but never go to a clinic or hospital seeking help.

Normal obsessions

Research studies carried out in different countries have shown that many people, randomly selected from the general population, in fact about four-fifths of them, report experiencing unwanted, unwelcome, even repugnant intrusive thoughts. These intrusions are similar in form and content to the obsessions of patients who seek help. The differences are that the non-patients tend to have the unwelcome intrusions far less frequently, are seldom distressed by them, and can easily dismiss them. In a study that was carried out in London some years ago, we asked a random sample of people to tell us if they ever experienced any unwelcome, objectionable, repugnant, and intrusive thoughts. These are some of the intrusions that they described:

- impulse to harm innocent people (e.g. children, elderly people);
- impulse to shout obscenities in church;
- thoughts of 'unnatural' sexual acts;
- thoughts of driving into pedestrians;
- images of her parents lying dead;
- objectionable sexual thoughts and images while attempting to pray;
- impulse to disrupt the peace at a gathering (e.g. shout or throw things);
- impulse to expose oneself;
- impulse to attack violently and kill a dog;
- sexual thoughts about religious figures, e.g. the Virgin Mary.

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The content of the intrusions was similar to the obsessions commonly reported by obsessive–compulsive patients.

Normal compulsions

Similarly, a large proportion of people have normal 'compulsions'. Various forms of checking behaviour are commonplace. Consider, for example, a person who goes round the house several times in order to make sure that all gas taps are closed, before leaving home; or a person who returns to the kitchen three or four times to check that the oven is switched off. Many people have minor compulsive rituals, such as always putting on the left shoe first, or always arranging a desk in a rigidly unchanging way. Studies have shown that such minor compulsions are common in the general population.

An excellent account of an eccentric non-clinical compulsion is provided in Boswell's biography of Samuel Johnson, the great eighteenth-century man of letters. Boswell described various 'singularities' or 'particularities' of Johnson's behaviour:

> 'He had another particularity, of which none of his friends ever ventured to ask an explanation. It appeared to be some superstitious habit, which he had contracted early, and from which he had never called upon his reason to disentangle him. This was his anxious care to go out or in at a door or passage by a certain number of steps from a certain point, or at least so as that either his right or his left foot (I am not certain which) should constantly make the first actual movement when he came close to the door or passage. Thus I conjecture: for I have upon innumerable occasions, observed him suddenly stop, and then seem to count his steps with a deep earnestness; and when he had neglected or gone wrong in this sort of magical movement, I have seen him go back again, put himself in a proper position to begin the ceremony, and, having gone through it, break from his abstraction, walk briskly on, and join his companion.'

Superstitions

There are similarities between superstitious ideas and some obsessions, and between superstitious acts and compulsive behaviour. Superstitions and certain obsessions are similar in that the person recognizes the irrationality of the idea or its associated activity, but prefers to err on the side of caution or safety. Like compulsions, many superstitious acts are carried out in order to prevent a misfortune from happening. However, there are many superstitious acts that

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are carried out in order to enhance the probability of good fortune; this is never the case with compulsive behaviour. Furthermore, obsessions can be distinguished from most superstitions in that the content of the obsession is often unacceptable or repugnant, leads to resistance, and causes distress. Obsessions are uniquely personal, whereas superstitions tend to be shared by many members of one's community or family.

Superstitions in children are discussed in Chapter 9.

Distress and interference

In deciding whether a diagnosis of obsessive–compulsive disorder is appropriate, it is essential to assess whether the person is significantly distressed by the obsessions and/or compulsions and whether they impair his normal functioning. Experiencing an unwanted thought once a day is unlikely to cause distress, but if it recurs dozens of times every hour it will be distressing and damaging. Similarly, checking all the gas taps once or twice before leaving home causes neither impairment nor distress, but if one were to check, say, 10 times on each occasion, that would interfere with one's normal functioning. Some patients reach clinics or hospitals only after the problem has progressed to such a degree that it produces drastic effects on their lives. For example, a woman came for help only when her compulsions had developed to such an extent that she was spending all her waking hours cleaning the house. Another patient gave up his job because he was increasingly fearful that he would pick up dangerous germs from contact with other people

Sometimes the person's obsessions and compulsions are more distressing to others than to himself. For example, a man who was excessively concerned about germs and dirt carried out intensive washing and cleaning compulsions. This might never have become a problem in itself, but he began to insist that his wife and mother-in-law did the same. If they refused he would get angry with them, and insisted that they both wash their hands at specified times, that they keep their towels only in designated safe places, and so on. The initial distress was felt not by him, but by those who were living with him.

In some, the compulsion is a minor one that does not affect one's life or functioning ordinarily, but can be a problem in certain circumstances. A 26-year-old man had the compulsion to look at any stranger a second time. If he noticed someone on the street who went past him, he would immediately turn round and look at the person a second time. This was a harmless if peculiar compulsion, and remained so until he developed a relationship with a woman. She noticed this behaviour and inferred that he was showing an unhealthy interest in other women, despite the fact that he was looking at members of both sexes

indiscriminately. The ensuing dispute nearly caused the break-up of their relationship. This problem brought him to a psychologist for advice; otherwise he might never have felt any need to seek help. In another case, a man was accosted by store detectives in a large supermarket. He admitted that he had acted in a way that might have given rise to suspicion. He explained that he had a compulsion to touch with one hand anything that he had touched with the other, even if he had to turn round and go back to the object to do so, and to make the hand in question free by transferring whatever he was carrying to his other hand. Until the embarrassing event, he had not realized what a spectacle he was making of himself in public places.

Unwelcome intrusive thoughts, even mild obsessions and compulsions, are common among people in the general population, and are not considered to be problems unless they cause distress or interfere with one's life. If a person experiences obsessions and/or compulsions that cause distress, or seriously affect his life, professional advice should be considered.

The matter needs to be kept in perspective. Only a small minority of people suffer from diagnosable obsessive–compulsive disorder, and, as noted, there is a tendency for the disorder to be over-diagnosed.

The relationship between obsessions and compulsions

Thus far, obsessions and compulsions have been discussed as separate phenomena. What is the relationship between them? In some of the examples of compulsions given above, a relationship between the two is clearly implied. In many cases the recurrent obsession drives the compulsive behaviour. We referred, for instance, to a woman who had recurrent intrusive thoughts (obsession) that she might go blind whenever she saw black objects, which led to her engaging in the compulsive mental activity of visualizing objects of different colours (see p. 11). To give a common example, when someone gets the obsessional thought that he might have touched something that contaminated him, he is likely to feel a strong urge to decontaminate himself by compulsively washing his hands repeatedly. These compulsions are sometimes described as 'neutralizing' behaviour because they 'put right' the disturbance caused by the obsession; they serve to neutralize the disturbance and/or threat. Many people try to neutralize their obsessional images, and learn by trial and error which tactics help them. They include attempts to substitute an acceptable image, or attempts to mask the intrusive image, and some people try to control them by blocking their eyes or blinking rapidly. These attempts at neutralizing seldom provide patients with more than brief relief. However, it is probable

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that many people who experience non-clinical obsessional images develop successful methods for coping with them, by neutralizing or other means.

Obsessions do not necessarily provoke compulsions; in many instances they generate and sustain avoidance behaviour. For example, avoidance behaviour is a common reaction to obsessional thoughts about sexual molestation.

In the large majority of cases of compulsive washing the driving force is a fear of contamination, and any actual or perceived contact with a contaminant will trigger the urge to wash/clean. Most commonly, checking compulsions are triggered by a perceived need to prevent accidents or misfortunes; these compulsions tend to occur in familiar situations at home or work, and are remarkably limited in range.

There are cases in which a compulsion recurs without any preceding obsession, as in the following example.

> A man had a compulsion to imagine car registration plates in a certain way. Every time he noticed a car licence number plate, he compulsively visualized the same plate with the number transformed in certain specific ways, such as squared, halved, or multiplied by two.

Many people with extensive touching compulsions do not report accompanying or preceding obsessions. Obsessions play little or no part in compulsive hoarding or in primary obsessional slowness (p. 59).

Elements of an obsessive–compulsive experience

The relationship between obsessions and compulsions can be illustrated by considering the elements that may be present in an obsessive–compulsive experience (Table 1.3).

Table 1.3 Elements of an obsessive–compulsive experience

Trigger	external/internal/none
Obsession	thought/image/impulse/none
Discomfort	+
Compulsive urge	+/–

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Table 1.3 Elements of an obsessive–compulsive experience (*continued*)

Compulsive behaviour	motor/cognitive/none
Reduction of discomfort	+/?
Fear of disaster	+/–
Inflated responsibility	+/–
Reassurance seeking	+/–
Avoidance	+/–
Disruption	external/internal/none

+ Indicates 'present'; – indicates 'absent'.

Trigger

A trigger is an event, or a cue, that sets off an obsession, a feeling or discomfort, or indeed a compulsive urge. A trigger may be external—i.e. something in the environment—or internal. For example, a young woman had the obsession 'Did I stab someone?' or 'Will I stab my children?' every time she saw a knife or any other sharp object: the knife was the external trigger that provoked her obsession. Internal triggers are mental events that lead to the same result. A man complained that every time he remembered his deceased father, he experienced distressing obsessions about death. The memory of the father was the internal trigger for his obsessional thoughts. As indicated in Table 1.3, triggers are not invariably present in all obsessive–compulsive experiences.

Discomfort

The occurrence of an obsession usually produces a feeling of discomfort. For many, this feeling is best described as anxiety, but some patients report that what they feel is not anxiety, but general unease, tension, or even a sense of guilt. 'Discomfort' is thus a preferred term because it encompasses all these emotions. Note that Table 1.3 states that obsessive–compulsive experiences always include discomfort; this may, however, not be so for non-clinical instances.

Compulsive urge

This is the urge, or drive, that the person feels to carry out a 'prescribed' behaviour, usually in order to reduce his discomfort. As Table 1.3 shows, not every obsessive–compulsive experience has this element.

Compulsive behaviour

This is the behaviour, overt or covert, that results from the compulsive urge. When the term 'compulsion' is used, it usually refers to the compulsive urge and the compulsive behaviour taken together.

Reduction of discomfort/anxiety

When the compulsive behaviour is carried out in the required manner, the patient normally feels relieved; the discomfort caused by the obsession (and/or the trigger, and/or the compulsive urge) is reduced or eliminated. Table 1.3 has included a question mark against this element of obsessive–compulsive experience. This is because there are instances in which carrying out the compulsive behaviour does not lead to a reduction of discomfort. Indeed, in a small number of cases the discomfort may even increase. Moreover, even when the compulsive behaviour reduces the anxiety or discomfort, the person may be left feeling frustrated and demoralized.

Fear of disaster

These fears arise frequently. The patient feels that a disaster will happen unless he neutralizes it by carrying out his compulsive behaviour. For example, an elderly man had the very strong fear that, if he did not check the gas taps in his house a certain number of times, the house would explode and go up in flames. The relationship between the specific disaster feared and the compulsive behaviour is, of course, not always logical. For example, a young man felt that his hand-washing compulsions prevented accidents occurring to his family members who lived in a different country. Similarly, patients who are troubled by fears of contamination, such as contracting AIDS, may wash excessively even though they know that washing your hands is not an effective precaution against AIDS.

Inflated responsibility

Many patients experience an inflated sense of responsibility—even for events over which they have no control. This is particularly common among those whose main problem is excessive checking. The inflated responsibility commonly generates anxiety and guilt.

Most examples of compulsive checking are attempts to prevent a misfortune, however obscure. The person strives for certainty that no harm will occur to others because of his negligence or supposedly poor memory. 'I must check at least ten times to be absolutely sure that the stove is off and will not cause

a deadly fire.' The drive to check repeatedly is intensified if, and when, the person feels solely or largely responsible for safety; for example, if they are the last person to leave the house or office. Curiously, there is a tendency for affected people to believe that an accident or misfortune is definitely more likely to occur when they are responsible for the task than when someone else is responsible. This is one example of the so-called 'cognitive biases', or skewed reasoning, that often occur in obsessive–compulsive disorders.

This is a selection of the ideas and feelings reported by people with inflated responsibility:

- 'I feel anxious and guilty if I have not made absolutely sure that my family and friends are safe';
- 'I feel especially responsible for checking the safety of my home and workplace—far more than my family and colleagues';
- 'If I have not repeatedly checked the total safety of my home, I feel uneasy and very reluctant to leave';
- 'I definitely feel responsible for constantly protecting my family and friends—I am always on duty'.

Inflated feelings of responsibility make such a large contribution to obsessive–compulsive disorders that some sufferers try to fend off responsibilities; for example, by refusing promotions to more responsible positions. They are likely to be distressed if their responsibilities are increased, and for this reason avoid such increases at work and home. However, a reasoned and reasonable transfer of responsibility for therapeutic purposes can be a great relief.

Reassurance seeking

Many obsessive–compulsive patients resort to reassurance seeking, usually from members of their families. Often, obsessional thoughts such as 'Will I go insane?', 'Did I do it properly?', and 'Do I need to check the taps again?' lead to the patient repeatedly asking for reassurance. When reassurance is received, the patient feels some brief relief from his discomfort, but the doubts and anxiety soon return. Frequently repeated requests for reassurance, often using the same words or phrases over and over again, strain the patience of friends and family.

In many instances, the requests for reassurance are not actually requests for information, despite the form of the question. The patient knows full well what the answer to his question really is. What seems to be a request for information is instead an indirect attempt to reduce his anxiety.

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Avoidance

This can be a significant factor in the clinical picture, although it is not part of the obsessive–compulsive experience as such, but rather a consequence of the obsessive–compulsive disorder. Usually, the avoidance behaviour concerns objects and situations that might trigger or exacerbate the obsession or compulsion. Those who fear contamination from dirt and germs strive to avoid what they believe to be any potential source of germs, be it a place or a person. Those with checking compulsions avoid tasks or situations that will increase their sense of responsibility and/or might be unsafe. A woman who had the obsessional thought that she might stab her children went to great lengths to avoid contact with knives, scissors, and other sharp objects. A man, who feared that he might catch AIDS, totally avoided certain areas of London.

A married woman in her twenties had the recurring thought that she had cancer. After several years of checking for cancer symptoms, she began to avoid any situation where she feared she might discover she had signs of cancer. She would not make her bed in the morning, or look at her used underwear, for fear of discovering blood stains which, to her, would be a sign of the dreaded illness. She even stopped looking at herself in the mirror or at her own body. She began to wear blouses and jumpers with long sleeves so that she could not see her arms, and trousers so that she could not see her legs. She stopped washing herself properly, as she feared that she might discover lumps on her body.

In some cases, certain 'unsafe' numbers, letters, or colours are avoided because the patient feels that such avoidance is necessary in order to avert some disaster, usually to a loved one. An illustration of this is found in the following example.

A married woman began to avoid the number four. Her husband's birthday was on the fourth day of the month and her obsessional logic dictated that, if she failed to avoid the number, she would cause great harm to him. She went to great lengths to avoid the number; for instance, she would skip the fourth page of books and magazines she was reading, would never write the number four, never eat four of anything (e.g. potatoes or slices of bread), and so on. Life became impossible when this gradually extended to all numbers beginning or ending with four, multiples of four, those that are adjacent to four, and so on, at which point she sought help.

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Disruption

When an obsessive–compulsive patient engages in his compulsion, he needs to carry it out precisely as he feels it ought to be done. If the behaviour is disrupted, the compulsive ritual is invalidated and needs to be restarted. For long and complicated rituals this can be extremely time-consuming and exhausting. The events that can act as disruptors vary from noise and other external disturbances to certain classes of experiences and thoughts, or the presence of other people. Hence, many compulsions—checking and/or cleaning—are carried out privately, when alone at night.

A middle-aged man had recurrent, intrusive thoughts and images of past homosexual experiences. This led to feelings of guilt and distress, and he felt compelled to 'cleanse his mind' with silent prayers to God, uttered in a certain fixed sequence. If, during this praying, images of homosexual acts arose in his mind, he had to restart the praying.

The need to form a safe or suitable thought before carrying out a compulsive or other act is common. If the action is disturbed by an unacceptable thought, the compulsive sequence has to be repeated in full.

A man engaged in prolonged hand-washing rituals whenever he felt his hands were contaminated by dirt and germs. He would usually wash them at the kitchen sink. If, during the activity, he happened to catch a glimpse of the kitchen waste bin, which he considered to be a dirty object, he felt his washing was not effective. So he would restart the washing ritual.

In some instances the person feels compelled to clear his mind by removing all other thoughts before attempting to carry out the compulsive activity; for example, removing distracting thoughts, all the better to concentrate on making sure that you have checked the stove correctly. Patients who carry out compulsive checking tend to lose confidence in their memory and in their ability to concentrate, especially when they are checking.

Other terms and concepts

There are two other key terms, which are commonly used to describe aspects of obsessive–compulsive disorder that need explanation. They are 'ritual' and 'rumination'.

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What is a ritual?

A ritual is a compulsion that is carried out in a rigid, set pattern, and a sequence of steps with a clear beginning and end. The following example illustrates an elaborate ritual reported by a man in his mid-twenties.

- Enter bathroom with left foot first.
- Close door with left hand, then touch door handle with right hand.
- Take towel from rail and keep it on edge of bath with left hand, then touch it with right hand.
- Take toothbrush from cabinet and place it on edge of wash-basin with left hand, then touch it with right hand.
- Take toothpaste tube from cabinet with left hand, then touch it with right hand.
- Unscrew and remove cap with left hand, then touch it with right hand.
- Squeeze tube to get enough toothpaste on to brush with left hand, then touch tube with right hand.
- Replace cap of tube with left hand, then touch it with right hand.
- Put tube back with left hand, then touch it with right hand.
- Pick up brush with left hand, then start brushing: teeth brushed in twos, from left to right, top row first, bottom row next, outside first, inside next, each set of two eight times; then, repeat whole process with brush in right hand, then again with left hand followed by same again with right hand.
- Open taps with left hand, then touch them with right hand.
- Wash brush under hot tap, held in left hand, then touch it with right hand.
- Put brush back in cabinet with left hand, then touch it with right hand.
- Rinse mouth, taking water with left hand, then with right hand.
- Look at self in mirror first with left eye, then with right eye.
- Begin to wash face, using left hand to splash water on face, then right hand.

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- Rub left side of face with left hand, followed by right side of face with left hand, then rub left side of face with right hand, followed by right side of face with right hand.
- Apply soap to face, in the same sequence as above.
- Rinse face, splashing water on face with left hand, then with right hand.
- Look at self in the mirror, first with left eye, them with right eye.
- Close taps with left hand, then touch them with right hand.
- Pick up towel with left hand, then touch it with right hand.
- Dry face with towel, left side holding towel in left hand, then right side holding towel in left hand, then left side holding towel in right hand, then right side holding towel in right hand.
- Look at self in mirror, first with left eye, then with right eye.
- Put towel back on rail with left hand, then touch it with right hand.
- Open door with left hand, then touch handle with right hand.
- Leave bathroom, with left foot first.

What are ruminations?

A rumination is a train of thought about a question or theme that is undirected, unproductive, and prolonged. Unlike obsessions, ruminations are not objectionable repugnant intrusions and are not resisted. During a rumination, the person appears to be deeply occupied, very thoughtful, and detached. Some authors and clinicians use the term 'obsessional rumination' to refer to all obsessional thoughts, but this is misleading. An example of a rumination is as follows:

> A young man had complicated and time-consuming rumination on the question: 'Is everyone basically good?'. He would ruminate on this for a long time, going over in his mind various considerations and arguments, and contemplating what superficially appeared to him to be relevant evidence. This never led to a solution or satisfactory conclusion.

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How does a rumination differ from an obsession? Many ruminations of obsessive–compulsive patients dwell on religious, philosophical, or metaphysical topics, such as the origins of the universe, life after death, the nature of morality, and so on. They are not unpleasant and are indulged rather than resisted. They rarely cause distress and are not disabling.

Unlike obsessions, ruminations are not clearly circumscribed, and they drift along rather than intrude into the patient's consciousness. Ruminations are not well-defined events; the theme or the question of the rumination is discernible, but the process of thinking about the topic is diffuse, often rambling, and open-ended.

> One young man reported extensive ruminations about what would happen to him after death. He would weigh up the various theoretical possibilities, visualize scenes of heaven, hell, and other worlds, try to remember what philosophers and scientists have said about death, and so on. There was never a satisfying end-point. A cycle of rumination, he reported, would take well over an hour.

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