OBSESSIVE-COMPULSIVE DISORDER
Theory, Research and Treatment

Edited by
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Edited by
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For Margot and Rachel (RGM),
Vasantha, Vin and Hesha (PdeS)
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This book is set out in five sections. The first, consisting of two chapters, explores the nature of obsessive-compulsive disorder (OCD). In Chapter 1, Krochmalik and Menzies examine the history of descriptions of the disorder, from the earliest references right through to contemporary accounts. Considerable attention is given to current classificatory and diagnostic criteria, with an examination of the differences between obsessive thinking, general worry, overvalued ideation and delusions. In Chapter 2, de Silva provides an exploration of the phenomenology of the condition, with multiple case descriptions that help capture the essential features of the disorder. It is hoped that a careful reading of the two chapters of Section 1 will provide clinical trainees, beginning practitioners and researchers with a solid foundation for the theoretical chapters that follow.

Section II considers various conceptual and theoretical aspects of the disorder. The Section opens with Frampton’s review of neuropsychological models (Chapter 3). Much of the experimental work in this area is shown to suffer from crippling methodological weaknesses, including the failure to control for multiple comparisons, co-morbid depression, medication and general speed deficits. In addition, there has been a general lack of underlying theory to guide experimentation. However, on a positive note, Frampton concludes that recent studies have begun to address these weaknesses and structural and functional neuroimaging have begun to strengthen theory and experimental design.

Frampton’s chapter is followed by Salkovskis and MacGuire’s review of higher-level cognitive models of the disorder (Chapter 4). Considerable emphasis is given to the way in which contemporary cognitive models may explain all of the symptomatology of the condition, rather than simply accounting for anxiety and avoidance. There can be no doubt that, in terms of the ability to account for the broad range of symptoms seen in OCD, cognitive models are well advanced on current neuropsychological explanations.

In Chapter 5, Davey, Field and Startup detail the way in which mood and cognitive decision rules may combine to produce perseverative, debilitating and ever-worsening rumination. Their thorough review of novel,
laboratory studies on the topic adds much to our understanding of obsessive thinking. It is our view that the future application of this material may substantially advance treatment procedures for OCD and related disorders involving worry.

In the last chapter in Section II (Chapter 6), Macdonald examines research on individual differences in search of an explanation for why some individuals develop OCD whereas others do not. After all, as Macdonald and several other authors in this volume point out, nearly all members of the community experience intrusive thoughts with content related to OCD themes. After a thorough examination of family and twin studies (with all of their methodological inadequacies), Macdonald concludes that biological factors provide only a small part of the susceptibility to the condition. Importantly, from a familial transmission perspective, she urges a further exploration of psychological/developmental pathways to the emergence of biased reasoning styles (see also Chapter 4).

Section III of the book describes the clinical presentations and subtypes. Seven chapters cover washing and cleaning, checking, hoarding, obsessional slowness, ruminations, atypical presentations and the spectrum disorders (with particular emphasis on body dysmorphic disorder). Each of the chapters provides a detailed description of the clinical presentation, supplemented with extensive case examples. A brief summary of the content and orientation of each of these chapters is provided below.

In Chapter 7, Jones and Krochmalik take us through a close analysis of the presenting features of compulsive washers and describe the new Australian treatment program designed to target exaggerated disease expectations in this subtype. On the basis of available data, Danger Ideation Reduction Therapy (DIRT) appears a viable alternative to standard interventions for compulsive washers. In Chapter 8, Rachman seamlessly combines 40 years of theory with clinical case descriptions and treatment recommendations for compulsive checking. He applies the general cognitive model of OCD to checking, emphasising the role of perceived responsibility in this subtype. In Chapter 9, Frost and Hartl describe the intriguing characteristics of hoarding, a behaviour that does not always appear to be driven by the popular constructs of threat expectancy and inflated perceived responsibility. The need to distinguish compulsive hoarding from appetitive collecting is stressed in this chapter. Rachman returns in Chapter 10 with an insightful coverage of primary obsessional slowness. Like hoarding, this OCD subtype presents some challenges to responsibility-based and threat-based models of the disorder. Rachman describes a raft of differences between this condition and more common presentations (i.e. washing, checking) that have led many to question whether primary slowness
is best considered a form of OCD at all. In Chapter 11 de Silva presents an overview of the nature and management of the various cognitive components of the disorder, namely ruminations, obsessions and covert compulsions. Cases with predominantly cognitive symptomatology have not routinely been included in randomised controlled trials, and so relatively little is known about the efficacy of treatment procedures for these problems. De Silva’s chapter makes a nice clinical companion to the earlier theoretical chapter of Davey, Field and Startup. Chapter 12, by Einstein and Menzies, presents a summary of the atypical presentations of OCD (including cases with sexual and aggressive compulsions, and counting rituals). The treatment recommendations of Einstein and Menzies centre on reducing threat expectancies, regardless of the idiosyncratic nature of a given client’s symptoms. Case illustrations demonstrate the way in which behavioural experiments may be applied in such cases. Finally, in closing Section III, Veale critically examines the notion of OCD spectrum disorders and, more particularly, body dysmorphic disorder. The epidemiology, aetiology, clinical assessment and treatment of this condition are described.

Section IV, covering approaches to assessment and treatment, opens with McColl’s review of the psychometric properties of the major measures of OCD (Chapter 14). McColl emphasises the need for the further development of reliable and valid instruments to assess the cognitive underpinnings of the disorder. The absence of such measures has limited the theoretical usefulness of treatment outcome research in the past.

In Chapter 15, Kyrios provides a detailed examination of the principles and practice of exposure and response prevention (ERP). Designing effective ERP programs is not as straightforward as many clinicians think, and Kyrios provides much advice on the many challenges facing the behavioral therapy (BT)-oriented clinician. Kyrios also reviews the outcome literature on this procedure, showing it to be the most established treatment for OCD. However, in Chapter 16, Marks begins her review of cognitive therapy (CT) by pointing to the limitations of ERP. There can be no doubt that the intense level of anxiety generated by ERP in many sufferers is largely responsible for the high drop-out rates associated with ERP programs. Effective alternatives to ERP are clearly needed. Marks’ provides a thorough review of the practical aspects of CT. The chapter covers a range of procedures that arise from Beckian models of anxiety and the writings of Salkovskis. Although outcome research on CT (from a Beckian perspective) for OCD is limited at present, existing data do suggest it to be a viable approach to the condition.

In Chapter 17, McDonough reviews the effectiveness of medical-based approaches to OCD. He opens with clear statements about the superiority of
current psychological treatments compared to all available physical treatments. At no point does he deviate from this position, suggesting that medication should ideally be reserved for ERP failures, drop-outs or refusers, or those with co-morbid conditions that clearly respond to medical interventions. As others in the book have argued (see chapters by Rachman, de Silva, Salkovksis and MacGuire, Einstein and Menzies, Jones and Menzies, and Marks), other cognitive-behavioural alternatives to ERP are also available, which further limits the usefulness of current medications. MacGuire provides a thorough review of the comparative data on the available serotonergic drugs in terms of efficacy, tolerability, safety, side-effects and management. Indications for neurosurgery are also described.

In Chapter 18, Shafran reviews the nature and management of OCD in children and adolescents. The phenomenology of the disorder in these groups is shown to be very similar to the phenomenology of OCD in adults. However, Shafran demonstrates that the cognitive-behavioural theories that dominate the adult literature (e.g. Salkovskis et al., 1998) are not those that underpin the most widely used cognitive-behavioural treatments for children with the disorder (March & Mulle, 1998). She calls for an increased cohesion between the science and practice of treating childhood OCD.

In the final chapter of Section IV, Bruch points to the high rate of ERP drop-outs and the inadequate treatment response to cognitive-behavioural therapy (CBT) in OCD as reasons to pursue more detailed examinations of the management of treatment-resistant cases. The clinical features of difficult clients are reviewed, including lack of motivation, the use of subtle avoidance strategies, and lack of understanding of the treatment rationale. In addition, Bruch considers the role of the therapeutic relationship and the critical importance of adequate case formulation in managing treatment-resistant presentations.

The final section of the book concerns professional issues. It consists of a single chapter by Harris and Menzies on training, resources and service provision. In Chapter 20, a number of issues that restrict access to effective treatment for those with OCD are explored. The chapter also covers the growth of support groups and computer-delivered treatment packages. The cost-effectiveness of these programs is reviewed. As the authors state, there can be little doubt that the computer age offers great opportunities for the cheaper delivery of effective psychotherapy. However, more RCTs will be needed before computer-based treatment becomes widely accepted as an alternative to individual, face-to-face psychotherapy for OCD.

Our book can be read as a single coherent volume, or as a set of five monographs, or even as 20 independent papers. Indeed, the chapters in Section III are intended to represent stand-alone guides to the major presentations of
the disorder. The clinician confronted with a given case can simply turn to the relevant subtype chapter in order to gain a quick (but thorough) coverage of the state of knowledge in the area. Although Section IV is completely dedicated to treatment, we have allowed (indeed encouraged) the contributors in Section III to provide coverage of the contemporary management of the subtypes they are describing. In this way, the stand-alone status of these chapters is achieved. If more formal (and lengthy) instructions in specific treatment procedures are required, the reader may turn to the relevant chapters in Section IV.

Finally, it should be noted that close and careful readers of this volume will no doubt identify several apparent inconsistencies across chapters. In regard to the relative importance of one cognitive construct over another, or the relative effectiveness of cognitive and behavioural procedures, or the explanatory power of a given theoretical position, or the merits of a particular series of studies, authors in our book may take differing positions. As the editors of the volume, we see this as a strength rather than a weakness. We have not attempted to force agreement between leaders in the field where it does not exist. Rather, we have allowed our contributors to defend their positions with reference to the extant literature and their clinical experience. In this way, the true state of knowledge and opinion on a given question is clear for all to see. Clearly, many issues remain to be resolved.

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SECTION I

THE NATURE OF OCD
Chapter 1

THE CLASSIFICATION AND DIAGNOSIS OF OBSESSIVE-COMPULSIVE DISORDER

Annette Krochmalik and Ross G. Menzies

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.
4 THE NATURE OF OCD

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 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,
‘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’)