



Phenomenology of Obsessive Compulsive Disorder

Ajit Avasthi, Deepak Kumar

Introduction

Sunil, an engineer in his late 20s, was obsessed with cleanliness. Tormented by thoughts of dirt and germs contaminating him, he would waste hours washing his hands- something that eventually cost him his job. Ritu, a college student, would invariably miss the first class in the morning. She would change her clothes umpteen times till she felt that she wore was just right. Every time Deepak had to leave the house, he would check, then recheck if the lights and gas stove were off. It all had to be done in a certain order. Things reached such a point for Sunil, Ritu and Deepak that they had to seek psychiatric help. And they are not alone. A large number of people suffer from what is termed as obsessive compulsive disorder (OCD). Even though there is a tendency among OCD sufferers to keep their illness a secret, they are increasingly seeking psychiatric help, often without the knowledge of their family. OCD is not a rare disease as was believed in former times. It figures among the most common of mental disorder. A startling two percent of the world's population suffers from OCD. The percentage in India is smaller (about 0.6%). But even this would translate into substantial numbers considering our population.

OCD is a chronic and potentially disabling psychological syndrome characterized by obsessional thinking and compulsive behaviour with varying degrees of anxiety, depression and depersonalization. It has been described as "the hidden disease". Only a few research

workers have attempted to describe OCD from a phenomenological point of view. Phenomenology refers to the exact study and precise description of psychic events, which are a primary requisite for the understanding of psychiatric disorders.

Tracing the history

OCD has been variedly described as:-

- Monomanie raiso nante - Esquirol
- Folie de doubte - Janet
- Abortive Insanity - Westphal
- Obsessive Compulsive Neurosis - Fenichel

Esquirol in 1838 was probably the first person to recognize obsessional disorder as a form of mental illness. He used the term monomania to describe a chronic disease of the brain, without fever, characterized by partial lesion of intellect, emotions or/and will. Pierre Janet in 1903 described 3 stages in the development of OCD - psychasthenia, forced agitations and stage of obsessions and compulsions, in his highly regarded work "Les Obsessions *et al* Psychasthenie". Freud in 1935 described obsessional neurosis as a self sufficient and independent disorder. Jaspers in 1963 in his phenomenological analysis identified five essential characteristics of obsessional symptoms:-

- a) A nonsensical, meaningless and absurd quality to the thoughts and actions of the obsessive that is recognized by the obsessive himself.
- b) The thoughts and acts having a compelling force.

From the Department of Psychiatry, Post-Graduate Institute of Medical Education and Research, Chandigarh.

Correspondence to : Dr. Ajit Avasthi, Deptt. of Psychiatry, Post-Graduate Institute of Medical Education and Research, Chandigarh.

- c) A belief that thoughts and actions can influence events (magical thinking).
- d) Need for order.
- e) Unacceptable impulses.

Mayer Gross outlined the boundaries of obsessions with delusions and overvalued ideas. Recently this issue was reviewed by Kozak and Foa (1).

Obsession	Overvalued idea	Delusion
Subjective feeling of compulsion over-riding internal resistance	Non-intrusive, unresisted acceptable idea pursued beyond bounds of reasons	False personal beliefs based on incorrect reference of external reality
Absurd, ego dystonic	Ego syntonic	Unshakeable conviction
Resistance	Strong effective component	
	Less than delusional intensity	

Obsessions and Compulsions-Concept

The psychiatric meaning of the word "Obsessional" is closely related to its usual dictionary meaning of "being harassed, pre-occupied or haunted by a thought or an idea". The word obsession refers to a thought, an idea or impulse accompanied by a subjective feeling of compulsion which patient tries to resist but can't get rid of. The term compulsion refers to do things in a certain number of times, touch various objects, carrying out cleaning operations by repeated washing and so on. Certain features of obsession and compulsion are:-

- a) An idea/impulse intrudes itself persistently and impelling into the person's conscious awareness.
- b) A feeling of anxious dread accompanies and frequently leads person to take counter measures against the initial idea/impulse.
- c) Obsessions or compulsions are undesired, unacceptable and uncontrollable.
- d) The person recognizes obsessions and compulsions to be absurd and irrational.
- e) The person feels a strong need to resist them. The symptoms may be manifested physically or behaviourally. In the absence of behavioural symptoms, nobody would know that anything

unusual is going on in the patient unless he/she chooses to disclose his/her purely private experience. Only the patient's compulsive acts can be observed and noticed by family members. Obsessive phenomena can occur in normal people, functional and organic psychosis, neurotic states, or as a constitutional trait (2, 3).

O-C Phenomenon in normal

Frequently observed in children in prepubescent years, much of the play of children takes a formalized and repetitive quality e.g. to hop at every fourth step or tread on paving stone and not on cracks in between or enter home with a particular ritual. These modes of behaviour become associated with fantasy and ideas of good and evil e.g. enter the home without the ritual would somehow be bad or unlucky.

Very similar to compulsive symptoms of a child are superstitions of an adult. Such harmless or meaningless acts, such as path being crossed by a cat or called from back while leaving the house or sneezed before initiating the work, take on a popular tradition of symbolic meaning for good or evil. The irrationality of the idea will be admitted, but a sense of discomfort will be present and the superstition-ridden may affirm that it is really better to be safe. Such a superstition is genuinely compulsive in nature. Childish rituals and superstitious acts resemble in many ways the rituals of religious people.

Another symptom experienced at some time by most normal adults that bears a close resemblance to the compulsive, or is perhaps genuinely compulsive, is the simple persistence of some content of the mind when it has ceased to serve any adaptive purpose.

Occurrence of Obsessional Phenomenon as a Constitutional Trait

Outstanding features is its rigidity, inflexibility and lack of adaptability, and its persistence and endurance even in face of obstacles; conscientiousness, love of order and discipline and moralistic values.

Minor degrees of obsessional traits add a quality of worth and stability to a personality and prove as valuable assets. If, however, they are present in marked degree,

they are usually hampering, lead to high level of mental inertia, indecisiveness and clinical decompensation and liability to clinical syndromes like OCD, anxiety disorders, depression, hypochondriasis and depersonalization.

Nosological issues

Both ICD-10 and DSM-IV define OCD in terms of its characteristic symptoms and not, as in case with depression, in terms of a syndrome. OCD is classified among anxiety disorders because:-

- A) Anxiety is often associated with obsessions and resistance to compulsions.
- B) Anxiety or tension is often relieved by yielding to compulsions.
- C) OCD often occurs in association with other anxiety disorders.

ICD-10 Criteria of OCD

It states that a person has obsessions, compulsions or both. Symptoms need not be present for prolonged periods, although definition specifies atleast 2 weeks. In practice, most patients would have suffered symptoms for considerably longer periods. It states that symptom should be "present on most days", although again, in practice, most symptoms are present everyday. ICD-10 recognizes 3 subtypes-predominantly obsessions, predominantly compulsions and mixed type.

Obsession and compulsion share following features, all of which must be present:-

- (i) They must be acknowledged as originating within the mind (patient's own thoughts) and not imposed by outside persons; this distinguishes OCD from thought insertion and schizophrenia.
- (ii) The obsession and compulsion must be repetitive and unpleasant and atleast one obsession should be acknowledged as either excessive or unreasonable.
- (iii) Patient must try to resist thoughts coming into their mind and try to resist performing the compulsive act; resistance to very long-standing obsession may, however, be minimal. Atleast one obsession that has been unsuccessfully resisted should be present.

(iv) Obsessional thought/compulsion must not be pleasurable in itself i.e. obsessional thought or compulsion provides relief from anxiety but doesn't give patient enjoyment.

(v) Symptoms may cause either distress or some kind of interference with social/individual function, usually by wasting time.

However, ICD-10 criteria do not include a "benchmark" to which levels of distress/time wasting can be compared. Moreover, they do not actually state how to make the judgement that the obsession/compulsion are not result of, for example, mood disorders or schizophrenia.

DSM-IV Criteria of OCD (APA, 1994)

Though it appears similar to ICD-10 criteria, it represents a slightly better definition of OCD. A patient presenting with either obsession, compulsion or both will be diagnosed as having OCD, and obsessional symptoms are defined within the definition of the disorder. The threshold for defining OCD in DSM-IV is slightly higher than that in ICD-10. It recognizes that O-C symptoms are time consuming and take more than 1 hour/day implying a relatively severe level of OCD. Exclusion criteria are also clearer than those of ICD-10 in that the content of obsession/compulsion must not be wholly restricted to the presence of another Axis-1 disorder. DSM has introduced a new subcategory called "with poor insight" based on empirical data, using expanded Yale Brown Obsessive Compulsive Scale (YBOCS) (4).

Obsessional Phenomenon in OCD

Obsessions and compulsions are important features of OCD and can be studied under 2 major headings-form and content. "Form" refers to the structures of the "phenomena" and "content" refers to be meaning reflected by it.

A. Forms of obsessions: (5,6)

- (i) **Obsessive doubt (60-70%):** Lingering inclination not to believe that a task has been satisfactorily accomplished.

- (ii) **Obsessive thinking (30-50%):** Thoughts which repeatedly intrude into conscious awareness, interfere with normal train of thought and cause distress to the patients and/or prolonged inconclusive thinking about a subject usually pertaining to future.
- (iii) **Obsessive magical thinking (30-40%):** Idea that is based on a magic formula of thought equals an act, frequently encountered in children (~10% of OCD subjects). It has been termed "obsessive conviction" by some authors (7).
- (iv) **Obsessive fear (25-40%):** A fear losing control and thus an apprehension of continuing a socially embarrassing act.
- (v) **Obsessive impulse (10-15%):** A powerful urge to carry out actions that may be trivial or socially disruptive or assaultive.
- (vi) **Obsessive image (4-5%):** Persistence before mind's eye of something seen or images of violent, sexual or disgusting nature that come repeatedly into mind.
- (vii) **Miscellaneous:** When the phenomenon is obsessional in nature but cannot be classified into any of the six forms mentioned above.

B. Forms of compulsions:

- (i) **Yielding compulsion (60%):** A compulsive act that gives expression to the underlying obsessive urge or thought e.g. a 29 year old clerk had an obsessive doubt that he had an important document in one of his pockets. He knew that this was not true, but found himself compelled to check his pockets again and again.
- (ii) **Controlling compulsion (<10%):** A compulsive act that tends to ward off and divert the underlying obsession without giving expression to it e.g. A 16 year old boy with incestuous impulses controlling the anxiety. These arouse by repeatedly and loudly counting to ten. Compulsions without associated obsessions have been termed as **autonomous** compulsion.

C. Contents of Obsessions:

- (i) **Dirt and contamination (40-50%):** Dirt, dust, menstrual blood, human or animal excreta,

other excretions of the body, germs, bacteria, virus etc.

- (ii) **Inanimate and impersonal (26%):** Mathematical figures, orderliness in arrangement or performance of certain tasks, locks, bolts, mechanical or electronic devices etc.
- (iii) **Sex (10%):** Sexual advances towards self or others, incest, masturbation, sexual competence etc.
- (iv) **Religion:** Existence of God, religious practices, mythological stories etc.
- (v) **Aggression (30%):** Physical or verbal assault on self or others, accidents, deaths, wars, mishaps, natural calamities etc.
- (vi) **Miscellaneous:** Not classifiable in any of the above-mentioned categories.

Phenomenologic Subtypes of OCD

Inevitably, in the beginning, the clinician is struck by the diversity of the clinical presentations of OCD. This initial impression, however, is soon replaced by the realization that the number of types of obsessions and compulsions are remarkably limited and stereotypic. OCD patients rarely have only one or two symptoms- multiple obsessions and compulsions are the rule although an individual's symptoms present at a given time exhibit certain understandable patterns.

There are three common clinical presentations: washers, checkers and pure obsessionals. Washing and checking alone or in combination constitute more than half the OCD phenomenon cluster. Insel and Arkiskal (8) suggested 4 common presentations of OCD- washers, checkers and pure obsessionals and primary obsessive slowness. Three core features may be more fundamental than symptom clusters; abnormal risk assessment, pathological doubt and incompleteness. Socio-demographic variables can have a pathoplastic effect on content of obsessions e.g. in Indian setting, "Suchibai Syndrome" is recognized in Bengali widows (characterized by repeated washing and purity rituals) (9).

Different authors from India have given varying percentages of obsessions and compulsions in their

studies. Some of these are as follows:-

Authors	Year	N	Common Obsessions	Common Compulsions
Akhtar <i>et al</i> (5)	1975	182	Obs. Doubts Contamination	Yielding
Kulhara & Rao (6)	1985	72	Obs. Doubts Obs. Thinking	Yielding
Khanna <i>et al</i> (10)	1990	410	Obs. Fears Obs. Thoughts	Washing Repeating
Girish Chandra (11)	2000	202	----	Washing Checking Hoarding
Prakash <i>et al</i> (12)	2000	1999	Doubts, fears	Yielding

Recent Indian Studies

- (a) Amitabh Saha and Sumeet Gupta (13). Studied phenomenology of OCD with a cross-cultural perspective. 40 patients of OCD (as per ICD-10) were studied using YBOC checklist. The common obsessions noticed were contamination (52%) and aggression (32.5%). Washing (57.5%) and checking (42.5%) rituals were the common compulsions.
- (b) Girish Chandra (11). Studied phenomenology of OCD using a factor analytic approach. Two hundred and two consecutive subjects with OCD were evaluated using the Yale Brown Obsessive Compulsive Scale- Symptom checklist and Scale for assessment of form and content. The data was subjected to factor analysis. The results suggest that there are factors that are broadly common to the two scales. The main factors that emerged were washers, checkers, hoarding and two pure obsessional factors. Authors commented that the cross-ritual validity of these factors has been established for an Indian population, and discussed the relevance of specific items between scales.
- (c) Prakash *et al* (12). studied the clinical profile of OCD at NIMHANS, Bangalore in a sample of 199 patients seen in the OCD clinic (the only OCD clinic in whole of India). They reported obsessional doubts (49%), imageries (20%), impulses (15%), thoughts (65%), as commonly

encountering obsessions. The common compulsions were yielding (60%), controlling (14%) and autonomous compulsions (1%).

Special symptoms of OCD:- Clinicians should be aware of certain less common symptoms of OCD as well:

1. **Hoarding:** Hoarding behaviour can be defined as collecting and being unable to discard excessive quantities of goods or objects that are of limited value or worthless. Hoarding is a symptom encountered in both OCD and obsessive compulsive personality disorder (OCPD).
2. **Intrusive music:** Musical obsessions have been reported by authors in OCD. The patients experience repetitive phrases, tunes or complex musical pieces that originate inside the head. Advertising jingles or popular tunes are common triggers. Musical obsessions have been described from Indian centres as well (5, 14, 15).
3. **Obsessional slowness:** Rachman (16) first described this in 1974. It was originally described as "a meticulous concern for orderliness". The patient takes hours to complete ordinary self-care tasks such as dressing or grooming because each task must be performed correctly, in sequence and "just right".
4. **Obsessions without insight or obsessions with psychotic symptoms:** In some of the earliest descriptions, obsessive symptoms have been closely linked to psychosis. A shift from obsession to delusion occurs when resistance (the internal struggle against obsessional urge or idea) is abandoned and insight is lost. The shift is usually precipitated by the stressful event. In obsessive patients with long-standing and severe illness, insight and resistance are only marginally present. They may recognize obsessions as ego-dystonic or irrational but fail to resist against them and show no elements of anxiety. This phenomenon is commonly seen in patients with schizotypal personality.

Obsessive phenomenon in obsessive compulsion spectrum disorder (OCS)

Over the past few years OC spectrum disorders have emerged as a unique category of related disorders with overlap in symptom profile, demography, family history, neurobiology, clinical course, treatment response etc. Which diagnosis belong under the umbrella concept of OC spectrum disorders is a matter of debate (17-19). Early advocates of the spectrum concept suggested the following collection (20): somatoform disorders (body dysmorphic disorder and hypochondriasis), dissociative disorders, eating disorders, schizo-obsessive disorders (OCD with loss of insight, OCD in patients with schizotypal personality disorder, OC symptoms in patients with schizophrenia), tic disorders, impulse control disorders, impulsive personality disorder. Others have suggested including certain habit disorders, phobias, PTSD, intermittent explosive disorder, OCPD. The spectrum can be viewed along a continuum with risk/harm avoidance on the compulsive end and risk/pleasure seeking on the impulsive end.

Conclusion

OCD has been known for quite sometime now and has interested the researchers, but studies have been mostly focused on treatment aspects and phenomenological studies have been few. Indian studies have come from two centers largely (PGIMER and NIMHANS). Lately a unique category of disorders has emerged that share some common key features with OCD. These are termed as "obsessive compulsive spectrum disorders". The extension of obsessions and related phenomenon in symptomatology of a host of disorders like impulse control disorders, eating disorders, body dysmorphic disorders, hypochondriasis, PTSD etc. underscores the importance of its clear understanding, delineation of boundaries and recognition. This can have a significant impact on differential diagnosis, treatment alternatives and prognosis of the patient. More transcultural studies are required to delineate the role of culture in pathogenesis of OCD and longitudinal studies would be ideal to study changes of phenomena in OCD over time. Clinicians must be aware of phenomenology of OCD as it is no longer a disease and are commonly presenting in psychiatric clinics around the country.

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