1. Various attempts have been made to formally classify psychiatric disorders, the two major systems being:

    1.1. The **ICD-10 Classification of Mental and Behavioural Disorders** (World Health Organisation, Geneva) is part of the 10th edition of the International Classification of Disease. This appendix follows the common abbreviation of ICD-10. It is the international system used by the majority of clinical psychiatrists in Great Britain.

    1.2. The **Diagnostic and Statistical Manual of Mental Disorders (fourth edition)** (American Psychiatric Association Washington DC). References to it in this appendix follow the common abbreviation of **DSM-IV**. It is a system devised mainly by and for workers in the USA, however UK psychiatrists were consulted in its formulation.

2. The two systems above have been in existence for many years but only in their current editions have they been closely comparable. This appendix is generally based on the ICD-10 system with any major comparisons and distinctions with DSM-IV being discussed where relevant.

3. This appendix summarises the clinical features and aetiology of obsessive compulsive disorder.

CLINICAL MANIFESTATIONS

4. This disorder is characterised by recurrent obsessional thoughts or compulsive acts which initially are resisted but may become less so with time. The symptoms include various features which have a similar quality of unpleasant intrusiveness and resistance. At all times however the patient recognises that, no matter how repugnant some of the thoughts are, they originate within themselves, ie insight into the nature of the condition is retained.

5. Normal people may sometimes experience occasional intrusive thoughts which they find disturbing or distasteful as they often contain aggressive or sexual themes, however this is not in itself indicative of any psychiatric abnormality.

6. Obsessional symptoms may be of several types:

    6.1. **Obsessional thoughts** are persistent thoughts, impulses or images that enter the mind despite the person's effort to exclude them. The thoughts are recognised as the individual's own but they are often repugnant and may produce feelings of guilt in that the person is ashamed he could think of such things. An essential feature is that the thoughts are resisted especially in the initial phases of the disorder: later on this resistance may become less.

6.2. **Obsessional rumination** is an endless internal debate on more complex themes such as how the world will end or the nature of worry. The difference between obsessional rumination and philosophising is the ideas in obsessional ruminations are resisted and they are constantly repeated without making any progress.

6.3. **Obsessional doubts** are ideas that previous actions have not been performed or have been incorrectly executed. People are uncertain that they have switched off lights, the cooker, locked the door etc. and although they go back and check often the feeling is repeated as soon as they leave the scene. Other doubts may be more esoteric such as whether sins have been adequately confessed or whether they have caused a road traffic accident.

6.4. **Obsessional impulses** are fears that the individual feels he will perform some dangerous, aggressive or embarrassing act. Examples are that they may pick up a knife and stab someone, jump in front of a train or off a high building, or to swear loudly in church. Whatever the urge the person does not want to carry it out, resists it strongly and does not act on it.

Compulsions (compulsive rituals or acts)

7. These are repetitive and seemingly purposeful behaviours performed in a stereotyped way. They are accompanied by a subjective sense that they must be carried out, the person however trying to resist them. Compulsions are often preceded by an obsessional thought for example that the person has touched a contaminated object and that they must therefore wash their hands. In the nature of the obsessional however this cleansing is often doubted and therefore repeated. In this way the act possibly serves to reduce the anxiety provoked by the obsessional thought. Unfortunately in some cases the anxiety increases after a ritual.

8. Compulsive acts may be of several types:

8.1. **Checking rituals** for example the repeated checking that lights and gas taps are turned off.

8.2. **Cleaning rituals** often take the form of repeated hand washing although household cleaning may be involved.

8.3. **Counting rituals** in which numbers are counted either silently or aloud and may become very complex, for example the numbers must be counted in threes up to quite large numbers, often the procedure starting again at zero if the person is uncertain that the counting has been correct.

8.4. **Dressing rituals** in which the person has to lay out their clothes in a particular way or put them on in a special order: again doubts lead to endless repetition of the ritual in case something may be got out of order. This may also be extended to other behaviours such as laying the table, cooking etc.

8.5. **Obsessional slowness**; the above rituals may lead to gross delays in completing tasks, however it has also been recognised that a small minority of patients may show an inherent extreme slowness in performing tasks.

9. Obsessional symptoms are frequently seen in depressive disorders and for a definite diagnosis of obsessive compulsive disorder to be made certain criteria should be fulfilled. Obsessional symptoms or compulsive acts must be present on most days for at least two weeks and interfere with normal functioning. The symptoms should be recognised by the patient as their own thoughts and there must be at least one act which is resisted, although others which are not resisted may be present. The thought of performing the act must not be pleasurable and the thoughts and images must be unpleasantly repetitive.

10. The majority of patients follow a chronic waxing and waning course with stress-related exacerbations and mild to moderate symptoms between the episodes. Approximately 15% of patients show progressive social and occupational deterioration with no improvement in symptoms. Patients with a deteriorating course often have an early onset and show a preponderance of men. The presence of a need for symmetry or exactness may be predictive of a poor prognosis.

AETIOLOGY

11. Obsessive compulsive disorder has been traditionally thought of purely as a neurotic condition, however evidence is now accumulating which suggests an association with brain dysfunction. It has been noted that several neurological conditions are associated with obsessional phenomena including post-encephalitic Parkinson's, Huntington's disease, Sydenham's chorea and lesions of the basal ganglia (the neostriatum and globus pallidus) and the frontal lobes.

12. Studies using PET scans have shown alterations in cerebral blood flow and altered glucose metabolism particularly in the cingulate cortex, the pallidum, putamen and thalamus. Some of the cases of extreme slowness reveal neurological signs such as cogwheel rigidity, upper limb asynkinesia and adventitious movements.

13. Obsessive compulsive disorders have been found in about 6% of parents of patients with the disorder, which is higher than the general population. Twin studies have provided evidence that heredity plays a role in the aetiology of obsessive compulsive disorder in contributing to the development of a particular personality type and by determining a general disposition to breakdown in the face of environmental stress.

14. The disorder occurs in 1.5%-3% of adult psychiatric patients. For the majority of patients, onset is in adolescence or early adulthood with peaks at ages 12-14 and 20-22 years of age. A history of tantrums, stealing or truancy in childhood is rare, indicating that obsessionals may have been unusually good or quiet as children. The mode of onset may be acute or insidious and most studies show no clear precipitant in 40% of cases although the mean time from onset to referral is 7 years.

15. Obsessive compulsive disorder is not necessarily associated with an obsessional pre-morbid personality and indeed many patients with the disorder have normal premorbid personalities.

CONCLUSION

16. There is increasing evidence that **obsessive compulsive disorder** is a disorder of brain function. The condition may be precipitated by stressful situations, however in 40% of cases no precipitating factor is found. Situational stressors may worsen pre-existing symptoms.

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