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Obsessive-compulsive disorder (OCD) is currently the subject of considerable research. This book offers a critical discussion of the most important theories that have been put forward to explain this disorder.

The book includes behavioural/learning accounts (and cognitive-behavioural supplements of these), accounts based on Pavlovian personality theories (such as those by Eysenck, Gray, and Claridge), Pierre Janet's account, cybernetic approaches, psychodynamic approaches, Reed's cognitive-structural account, and biological approaches. Therapeutic approaches to the disorder are also considered, insofar as they are relevant to these theories. An analysis of the concept of OCD is also presented, together with a critique of the existing definitions of the disorder.

This book is unique in both the comprehensiveness and the depth of its coverage of theories of OCD. It also offers an entirely new approach to the definition of the disorder.

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Ian Jakes was an exceptionally gifted young scientist and clinician who died tragically at the age of 34, shortly after the manuscript of this book had been delivered to the publishers. Ian's close colleague and mentor, Padmal de Silva, kindly undertook the task of steering the book through to the final printed version.

JEFFREY A. GRAY

Ian Jakes (1960–1995) studied psychology and philosophy at Cambridge University and then joined the Institute of Psychiatry, University of London, for postgraduate training in clinical psychology. After qualifying, he stayed on to carry out research into obsessive-compulsive disorder, leading to his Ph.D. At the time of his death resulting from acute leukaemia in April 1995, he was working both as a University lecturer and a clinical psychologist. This book represents some of the theoretical work done by Ian in the last years of his life. It provides an incisive and constructive critique of the major theoretical approaches to obsessive-compulsive disorder. Those interested in obsessive-compulsive disorder, whether from a theoretical, clinical or research perspective, will find this book invaluable.

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To my parents, Charles and Ruth Jakes

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The best lack all conviction, while the worst
Are full of passionate intensity

W. B. Yeats
"The Second Coming"

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Synopsis of *Theoretical approaches to obsessive-compulsive disorder*

This book discusses the diagnostic criteria for, and a variety of theoretical accounts of, obsessive-compulsive disorder (OCD).

The definition of OCD

It is suggested that the existing defining criteria for OCD are inadequate, that there is no single set of features that is both common and peculiar to all instances of the disorder, and that there is no single way in which OCD may be distinguished from phobic or delusional states; a number of different ways in which these distinctions between OCD and other states may be drawn are noted.

The approach to the definition of OCD that is defended here may, in suggesting that no single set of features is both common and peculiar to all instances of the disorder, be similar to the definition of schizophrenia that is offered by DSM-III-R – both definitions provide, that is, what DSM-III-R terms polythetic criteria.

It is not suggested that the subdivisions of OCD symptoms, of which the definition that is offered here is composed, are important from the point of view of such matters as the explanation or treatment of the disorder. It is too early to claim any such importance for these subdivisions, and indeed, it is argued that any differences among OCD patients in terms of the aetiology and/or treatment of their disorder may turn out to be unrelated to differences in the kinds of symptoms they report.

Behavioural/learning accounts of OCD

It is argued that most of those aspects of the behavioural/learning account of OCD that are considered here meet with substantial difficulties. This account is correct in suggesting that many obsessions and compulsions are provoked by environmental cues and that exposure to these cues causes many patients to experience discomfort. It is argued, however, that attempted explanations of the repetitiveness of some compulsions from a behavioural point of view are implausible and that behavioural/learning theorists may have exaggerated the importance of discomfort reduction to the maintenance of compulsive behaviour. Discomfort reduction is not necessary to explain the maintenance of such behaviour, and some brief remarks are offered as to how a common explanation might be provided for the maintenance of both discomfort-reducing and discomfort-increasing compulsions.

The behavioural/learning approach encounters difficulties in explaining both the selectivity of OCD's feared stimuli and the paradoxical failures of these

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stimuli to extinguish. It is argued that the incubation and preparedness hypotheses fail to meet these difficulties.

It is noted that the behavioural/learning account is not unique in providing an explanation of why exposure with response prevention should be effective with OCD; other accounts are able to provide alternative explanations. Accounts by behavioural theorists of those obsessions that are not provoked by environmental cues have helped to inspire a new approach to the treatment of such obsessions. The efficacy of this approach has as yet not been established, however, and it is argued that behavioural accounts, which stress the supposed similarities between these kinds of obsessions and phobic objects, fail to explain why such obsessions should occur. Doubts are also raised as to the value of an alternative theoretical approach in which obsessions are seen as a sign of unprocessed emotion. Some further work by behaviour therapists is noted in connection with Janet's account of OCD.

The cognitive-behavioural approach

It is argued that the cognitive-behavioural account provides no very compelling reason for supposing the appraisals it presents in the case of some instances of OCD (those involving blasphemous, sexual or aggressive obsessions) either to be the primary source of distress or to be the mechanism, in conjunction with neutralising behaviour, that converts normal obsessions of this kind into abnormal obsessions. The interesting connection between some aspects of the cognitive-behavioural account as applied to cases of this kind, and the observation that OCD patients are sometimes people of "tender conscience", is noted. A possible alternative explanation of OCD's occurring in such people is also briefly considered. In other cases of OCD, it is argued, the appraisals cited by the cognitive-behavioural account describe what needs to be explained, rather than provide an explanation. The cognitive-behavioural account, in making many of the same assumptions as the behavioural/learning approach, may also face some of the difficulties that approach encounters – for example, it may, in its present form, share the inability of the behavioural/learning approach to explain the repetitiveness of some compulsive behaviour.

Accounts of OCD based upon personality theories derived from the work of Pavlov

Accounts from the perspective of Pavlovian personality theories suggest that OCD patients should tend to be introverted, but evidence is presented that contradicts this claim. From the evidence quoted, introversion appears to be exhibited more by those OCD patients whose major difficulty is cleaning than it is by those whose major difficulty is checking. This, of course, leaves open the possibility that the neuroticism of OCD patients may play a role in producing their symptoms, as writers such as Eysenck, Claridge and Gray suggest, and indeed, it may even be (once again consistent with the views of Eysenck, Claridge and Gray) that

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in those OCD patients in whom both introversion and neuroticism occur, these two features combine to play a role in producing the symptoms observed. But even if all of this is accepted, it is clear that such temperamental characteristics as neuroticism and introversion cannot deliver a full account of the symptoms reported by OCD patients. Thus, these temperamental characteristics are supposed to be exhibited not only by patients suffering from OCD, but also by patients with other dysthymic disorders, and so these characteristics could not begin to explain why, for example, one patient develops neurotic depression or a phobia while another develops OCD. Similarly, there appears to be a wide gulf between the mere emotional reactivity that is supposed to characterise neurotic introverts, on the one hand, and, on the other, the bizarre preoccupations, repetitive behaviour and failures of memory that are reported by many OCD patients.

It is this gulf that Gray's account attempts to bridge, whereas Claridge tries both to do this and to explain – in terms of individual differences in attentional style – why some patients develop OCD rather than phobias or depression. Both of these accounts, it is argued, meet with difficulties. Gray's appears for a number of reasons not to provide a plausible explanation of the various OCD symptoms he discusses, including those that involve checking difficulties – the phenomena for which this account at first appears to provide an especially elegant explanation. It is noted that Claridge's account possesses a number of important strengths but relies too heavily on Reed's formulation of obsessional difficulties, thus encountering a number of the problems faced by that formulation.

What may be the most powerful argument considered in this discussion of personality theories derived from the work of Pavlov owes very little directly to those personality theories, this argument being that it may be possible to explain the contents of some OCD symptoms (particularly those involving, as Gray suggests, fears of dirt/contamination and/or cleaning behaviour) in terms of the evolutionary advantage that such fears and behaviour may be hypothesised to have bestowed. It is also noted, however, that the contents of various other OCD symptoms could not be explained in these terms. In those cases where evolutionary arguments do possess some force, it is suggested, once again consistent with Gray's and some of Claridge's remarks, that the most plausible mechanism through which such evolutionary pressures could exercise this influence may be that of innately acquired, rather than prepared, fears.

Janet on OCD

Janet included OCD, among other conditions, in the category he termed *psychasthenia.* Pitman praises the clinical astuteness of Janet's work and suggests that it is not so much Janet's theory of psychasthenia, but rather his observations and treatment suggestions concerning the disorder, that have stood the test of time. Janet's theory of psychological tension and his speculations as to a physiological tension corresponding to it, were, according to Pitman, an unsuccessful

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attempt to make sense of Janet's observations concerning psychasthenic patients. Some of these observations, however, such as those concerning the interpersonal difficulties encountered by these patients and the co-morbidity of the various symptoms they report, remain important contributions. In the light of Reed's interpretation, it needs to be added that opinions differ on how Janet's theory of psychasthenia is to be understood, but this turns out not to be a reason for questioning Pitman's lack of confidence in the theory – Reed's own account of OCD, which has much in common with his interpretation of Janet, meets with substantial difficulties. It is of interest that some of Pitman's suggestions as to the nature of OCD, made while outlining a cybernetic model of the disorder, have some similarities with Reed's account. It is also noted that the account of some symptom contents to which Janet was led by his theory of psychological tension may have been too readily rejected by writers such as Pitman. Something like Pitman's psychodynamic account, on the one hand, and Janet's account, on the other, may provide contrasting predictions as to the likely outcome of using assertion training with some (but not all) of the psychasthenic patients described by Janet. It is noted that some behaviour therapists have used this intervention with OCD patients (also see later).

Doubts have been raised regarding the extent to which Janet's treatment suggestions amount to the recommendation to use exposure with response prevention with OCD patients. Concerning Janet's clinical observations, doubts have also been raised as to the extent to which these would apply to all OCD patients.

Pitman's cybernetic model of OCD

In presenting a cybernetic model of OCD, Pitman discusses a number of interesting cases where symptoms involve indecisiveness, perfectionism and conflict. But, insofar as the cybernetic model makes substantive suggestions as to the explanation of OCD – in terms of a postulated internal comparator mechanism containing a fault that makes it more difficult to extinguish error signals – it encounters a number of difficulties, the most important of these being in making sense of the motivation of patients suffering from the disorder. Insofar as these difficulties are avoided – by supposing the internal comparator fault to produce error signals that are, in contrast, abnormally strong, or by presenting the cybernetic model within a "conflict/displacement" account – it appears that the cybernetic component of these accounts fails to make any substantive contribution to them. In its present form, therefore, it must be concluded that the model does not significantly advance our understanding of OCD.

A psychodynamic approach to OCD

Some psychodynamic theories of OCD are briefly outlined, and a case discussion presented by Malan is examined in some detail. Four features, it is argued, give this case discussion its psychodynamic character. These four features are the

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account's reference to unconscious mental processes, its formulation of the patient's concerns as having symbolic significance, its claim that the patient's difficulties may be understood as having occurred in order to serve some purpose for him, and its claim that insight into hidden feelings derived from childhood experience is of fundamental importance to therapeutic outcome. It is argued that, if there is anything of a psychodynamic character about the first of these features, this is merely a semantic matter. The other three features are all more substantial, but reasons are offered for thinking none of them to be important to the understanding of the case presented by Malan. The possible relevance of this case to the understanding of OCD in general is discussed.

There are links between some of Malan's remarks, and Freud's ideas concerning the anal-sadistic stage and OCD – in particular, the emphasis in Malan's account on the patient's supposed efforts to control his own anger, and Malan's relating this to the theme of the elimination of body products. Reasons for accepting an alternative account of the exaggerated importance of body products are offered.

One might, then, conclude that doubts are justified as to the psychodynamic aspects of Malan's account.

These points do certainly not imply that Malan's discussion fails in all respects to illuminate OCD. Some of Malan's remarks seem as if they may do so – in particular, his suggestions that unassertive behaviour may be important in understanding some cases of OCD and that encouraging constructive assertion may be a useful intervention for these cases.

Cognitive style/deficit approaches to OCD: Reed's account

Reed originally argued that obsessional disorders all stem from difficulties in the spontaneous structuring of experience, which in turn lead to compensatory overstructuring. Reed himself later pointed out that this hypothesis, as it stands, makes poor sense of some cases, especially those involving checking and rumination. He attempted to remedy this by supplementing his account with the concept of redintegration. It is suggested that this supplement is implausible. It is also argued that Reed's account makes poor sense of OCD symptoms in which doubts, indecision and ritualising do not play a major role or do not appear at all. Certain aspects of some of the OCD symptoms that do involve these characteristics, furthermore, are not explained by this account – in particular, the fact that, in many cases, certain themes tend to feature (that is, OCD's feared stimuli exhibit selectivity) and the fact that these difficulties sometimes involve just a few areas of the patient's life.

It is argued that Reed's hypothesis also fails to explain the motivation of OCD patients in carrying out their compulsive behaviour. A suggested revised version of Reed's thesis can explain why at least some OCD patients are highly motivated to behave as they do, but this thesis fails to account for various observations – once again, especially those that tend to be associated with checking difficulties. It is argued that a partial explanation of such difficulties from this perspective may be

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possible, however. This revised thesis is also argued to be poor at distinguishing OCD patients from other psychiatric groups, including phobic and deluded subjects.

The type of laboratory evidence Reed presents in favour of his thesis is argued to provide only weak support, while the clinical observations Reed cites to this same end are at best controversial. Laboratory evidence is introduced that is inconsistent with that cited by Reed. Objections are brought against Reed's comments as regards the use of behavioural and cognitive therapy and the use of assertiveness training with OCD.

It is also argued that Reed's account misrepresents the role of anxiety in OCD and carries implausible implications as to the relationship both between OCD and the obsessional personality/personality disorder and between OCD, on the one hand, and anxiety and depressive disorders, on the other.

A number of further comments are offered on Reed's discussion of external structuring; his interpretation of Janet; his account of the experience of compulsion; and his comments on the definition of OCD as well as on the definitions of the obsessional personality and personality disorder.

What of Reed's account may be salvaged from the foregoing discussion? The account appears to be most plausible when regarded as a partial explanation of some OCD difficulties – in particular, those where one observes the patient's having, in Reed's terms, problems structuring some task and tending to perform it in an overstructured manner. Among the best examples of cases of this kind appear to be some instances involving contamination fears and cleaning behaviour.

The revised thesis seems most likely to provide a full explanation in the case of those OCD symptoms where some unlikely outcome is feared by the patient, but where neither constant doubts about, nor endless repetitions of, compulsive behaviours are observed. Many cases involving cleaning difficulties correspond to this profile.

Both Reed's account and the revised thesis, therefore, seem to be most plausible in many cases of cleaning difficulties. It needs to be stressed, however, that the greater plausibility of these approaches as regards cleaning problems really amounts to no more than the absence of the objections that arise regarding the application of Reed's account and the revised thesis to other kinds of difficulties, such as checking behaviours and discrete obsessional thoughts, images and impulses. There are, that is, no positive grounds for accepting either of these approaches even in the case of cleaning problems, and it remains entirely possible, therefore, that the cognitive factors discussed by Reed will turn out to be entirely secondary phenomena in OCD, playing only a minor, or even no, role (when they appear at all) in producing the pathological thinking and behaviour that is observed.

Biological approaches to OCD

A variety of biological findings concerning OCD patients, and proposed animal models of these patients, are considered, along with a number of the psychologi-

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cal accounts of OCD that are offered by biological theorists. It is argued that these biological findings, if sound, would support the claims of some biological theorists that abnormalities in the basal ganglia, and perhaps also the frontal cortex, play some role in producing and maintaining OCD; these biological findings are not, however, subject to either detailed or comprehensive scrutiny here. Claims that the limbic system may also be involved in causing OCD (a claim also made by Pavlovian personality theorists) are also considered, and some possible difficulties for these claims are noted. As regards the psychological accounts that are considered, it is suggested that a conflict/displacement approach is perhaps the most plausible; nonbiological work that may support this approach is noted.

Concluding remarks

Can an example be provided, then, from among these various theoretical approaches to OCD, of some ideas concerning the disorder that are shared by a number of these approaches and that, while no doubt failing to provide a complete account of OCD, can be said to have made some progress in understanding the disorder? One example is considered. It has been pointed out in connection both with Janet's discussion of OCD and with Malan's psychodynamic approach, that a tendency to unassertiveness is observed in some OCD patients. These approaches suggest that a failure to act assertively and/or to express aggressive feelings may help precipitate the symptoms of some OCD patients and that these symptoms may, therefore, be alleviated by an intervention that successfully encourages these patients to behave more assertively and/or to express their aggressive feelings to a greater extent. Similar suggestions have been made by some behaviour therapists who use assertiveness training with OCD patients, and some aspects of the psychological accounts offered on the basis of biological research into the disorder also overlap to some extent with these suggestions. These ideas are critically discussed. An attempt is made to show that at least some of these suggestions are theoretically progressive – that is, that they offer explanations and predictions that cannot readily be supported by other accounts of OCD; this is followed by a few remarks as to whether or not these suggestions may also be regarded as empirically progressive – whether or not, that is, the explanations and predictions that are provided by these suggestions have been confirmed.

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