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Obsessive-Compulsive Disorder: Gender Differences Among Washers and Checkers

Jennifer Leigh Siervo

OBSESSIVE-COMPULSIVE DISORDER: GENDER DIFFERENCES AMONG WASHERS AND CHECKERS

JENNIFER LEIGH SIERVO B.A.

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Abstract

This research project thoroughly examines Obsessive-Compulsive Disorder to see if there are any gender differences between compulsive washers and checkers. The null hypothesis is that there are no gender differences between the compulsions of washing and checking. Thirty-one subjects from a local self-help group voluntarily participated in this study. Of the thirty-one participants, thirteen were men and eighteen were women. The Maudsley Obsessional-Compulsive Inventory was used to obtain total obsessions scores, as well as washing and checking scores. The mean scores for men and women for the total obsessions scale were compared. The women reported a higher number of compulsions then the men. The Pearson chi-square statistic was used to determine if there was a correlation between washing and checking compulsions, and gender. The results of the statistics revealed there were no gender differences between the compulsions of washing and checking.

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Committee

Pamela Nickels, EdD
Chairperson

Becky McKenna, Ph.D.
Adjunct Professor

Jacquelyn Fischer M Ed
Outpatient Clinician
Crider Center for Mental Health

Dedication

I would like to dedicate this thesis to my brother, Andy. Without his presence in my life and his special qualities I would have never fallen into the field of Counseling.

Acknowledgement

This acknowledgement goes out to my husband and my parents. I would not have made it this far without their encouragement, support, extraordinary patience. I sincerely thank you.

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Chapter I

Introduction

Over the last several years Obsessive-Compulsive Disorder (OCD) has been featured in major papers, magazines, a best-selling book, and has been a topic on numerous radio and talk shows. As a result, people have observed a greater public awareness of the disorder. OCD is often chronic and is considered to be among the most treatment resistant and debilitating of the anxiety disorders (Rheume, Ladouceur, Freeston, & Letarte, 1995).

The most familiar forms of compulsions are washing, checking, repeating, ordering, and hoarding. These compulsions consume hours of an obsessive-compulsive's day, and must be performed to reduce the anxiety that is provoked by fears or doubts that surround the compulsive acts.

There are two basic theoretical models that attempt to explain the cause and progression of OCD. The behavioral model suggests a stimulus that was once neutral becomes associated with fear and eventually avoidance through compulsions. "In a stressful period, ritualistic activities prove to have powerful anxiety reducing effects" (Emmelkamp, 1982 p. 42). In other words, according to the behavioral model, the stored

representation of past events are activated at the time of a stressful life experience.

The cognitive theorists believe OCD develops due to unrealistic threat appraisals, erroneous beliefs, and negative automatic thoughts (Salkovskis, 1984; van Oppen & Arntz, 1994). The ritualistic behaviors are maintained not only to reduce anxiety but to address the obsessive-compulsive's need for certainty before terminating an activity.

The concept of perceived responsibility appears to be an important component of OCD. This perceived responsibility is excessive to the point where an OCD patient believes they have the power to prevent possible catastrophic events (Rheume et al., 1995). There is an overestimation of the risk of negative consequences for a variety of actions.

Clinicians face several difficulties in the diagnosis of OCD due to its similarity to Obsessive Compulsive Personality Disorder (OCPD), and the presence of secondary symptoms. Unlike a person with OCD, a person with OCPD seldom believes their obsessions and compulsions are unreasonable nor intolerable (Gibbs & Oltmanns, 1995). Anxiety is a key element that people with OCPD do not experience.

Obsessive-compulsives often present themselves to clinicians with

secondary symptoms of depression, personality disorders, or alcoholism (Barlow, DiNardo, & Vermilyea, 1986; Farid, 1986, Steketee, 1993). This may be due to the debilitating effects of OCD, and intense feelings of frustration in the inability to control their symptoms. The comorbidity in OCD presents a problem in formulating an accurate diagnosis and therefore prescribing the proper treatment.

There are few assessment tools specific to diagnosing OCD. Due to the multiplicity and wide range of symptoms, individual measurements tend to be unreliable (Yaryura-Tobias & Neziroglu, 1983). Contaminates of assessment measures include the complex relationship with both anxiety and depression and treatment with antidepressants.

Statement of Purpose

According to Ammerman and Herson (1993), the majority of patients report the onset of symptoms before age thirty, most typically between late adolescence and early twenties. The ratio of males to females with OCD is about 1:1, with more women reporting washing compulsions and men reporting checking compulsions (Ammerman, 1993; Yaryura-Tobias & Neziroglu, 1983). Most research has addressed treatment modalities and assessment tools, but little was found on gender differences among the compulsions. The purpose of this paper is to thoroughly

examine OCD and the compulsions associated with OCD to see if there are any gender differences. The null hypothesis is that there are no gender differences between the compulsions of washing and checking.

Chapter II

Literature Review

History

OCD may be traced back to the beginning of man. "Primitivism, the Middle Ages, and contemporary age describe the links among man, religion, and psychiatry" (Yaryura-Tobias & Neziroglu, 1983, p. 1). For example, the use of ceremonies as a means of appeasing anxiety and fear, which are provoked by the presence of natural phenomena that are unexplainable to man. Another example of the relationship between religion and psychiatry is the analogy between taboo and obsessional neurosis. In both, there is the insistence on rigid abidance to rules and prohibitions. When a prohibition is trespassed, a ceremony or ritual must be performed.

Diagnostic Criteria

The diagnostic criteria for OCD went through some revisions from the Diagnostic and Statistical Manual of Mental Disorders-Third Edition Revised (1987) (DSM III-R) to the DSM IV (1994). Foa and Kozak (1995) performed a field trial on two issues relevant to revising the DSM III-R criteria for OCD. First, the requirement was that symptoms of OCD

be viewed by the patient as excessive and unreasonable. The second issue was, the presence of mental compulsions in addition to behavioral compulsions. The results showed that a large majority of patients were uncertain about whether their OCD symptoms were unreasonable or excessive and most of them had mental and behavioral compulsions.

This brings up the issue of insight which was a major component of the revisions of OCD in the DSM IV. The problem with the poor criteria on insight in the DSM III-R lead to misdiagnosis. "Clinicians with extensive experience with OCD can compensate for the imperfections in the criteria, but for the inexperienced clinician this can result in a misdiagnosis and lead to treatment with antipsychotic medications rather than antiobsessional medications or behavior therapy" (Foa & Kozak, 1995, p. 90).

A correction of this problem in DSM IV was proposed to eliminate such misdiagnoses. The subtype "with poor insight" was included in the diagnostic criteria. "Inclusion of this subtype in diagnostic criteria may also encourage researchers to explore the relationship among insight and other aspects of the psychopathology and treatment" (Foa & Kozak, 1995, p. 91).

In the DSM III-R (1987) the concept of mental compulsions (e.g.,

silent counting, praying, repeating) is introduced through the definition of obsessions rather than that of compulsions. Foa and Kozak (1995) explained that there are two types of obsessive compulsive thoughts: the kind that a person tries to suppress and the kind with which a person attempts to neutralize with another thought. The criteria for compulsions does not mention neutralizing thoughts. The concept of mental rituals is introduced through the definition of obsessions rather than that of compulsions in DSM IV as well. Foa and Kozak (1995) emphasized that the identification of such mental compulsions is important because it can eliminate confusion between OCD and other disorders with rumination; only individuals with OCD have mental rituals. "Perhaps because the distinction between obsessions and cognitive compulsions has not been delineated clearly, there have been no studies of such compulsion" (p. 91).

Appendix A displays the diagnostic criteria in the DSM IV (1994). The primary feature of OCD is a recurrent or persistent idea, thought, image, feeling, or movement which is accompanied by anxiety and a desire to resist it (Barlow, 1985). In the attempt to reduce the anxiety provoked by these persistent thoughts and images, a compulsion or ritual is developed and performed. "By definition, compulsions are either clearly excessive or are not connected in a realistic way with what they are

designed to neutralize or prevent (DSM IV, 1994, p. 418).

Obsessions

Specifically, obsessions many times have a quality of magic, by which patients believe they are able to undo or to change events, just by the mere thought process (Yaryura-Tobias & Neziroglu, 1983). Obsessions are endless, nonmotivated, and, in a way, circular. The obsessions start at a point and come back to the same point. "The obsessions appear in an intrusive manner, usually gradually and invasively" (Yaryura-Tobias & Neziroglu, 1983, p. 10).

Goodwin (1986) defined several forms of obsessions. "Obsessional ideas" are thoughts that repetitively intrude into consciousness, interfering with the normal train of thought and causing distress to the person. "Obsessional images" are vividly imagined scenes, often of a violent, sexual, or repulsive nature that repeatedly come to mind. "Obsessional convictions" are beliefs that are often based on the magical formula of thought equals act. They are characterized by ambivalence; the person believes and simultaneously does not believe. Prolonged, inconclusive, thoughts about a subject to the exclusion of other interests are "obsessional ruminations." The subject is often religious or metaphysical. Why and

wherefore questions that are as unanswerable as they are impossible to resolve are often present and result in checking and rechecking over and over. "`Obsessional doubts' may well be the most prominent feature in OCD" (Goodwin, 1986, p. 173). The person tries to turn his/her attention elsewhere, but cannot; often the more the person tries, the more intrusive and distressing the thoughts become. "Obsessional impulses" are typically related to self-injury; injury to others; or embarrassing behavior. "Obsessional fears" are often of dirt, germs, contamination; of potential weapons, of being in specific situations, or performing particular acts. Finally, there are "obsessional rituals" or "compulsions" which are repetitive, stereotyped acts or counting, touching, arranging objects, moving in specific ways, washing, tasting, or looking. In other words, they are an obsession expressed as an action. "The compulsions are inseparable from the obsession from which they arise" (Goodwin, 1986, p. 173).

Compulsions

Compulsions are the most readily apparent features of OCD and take a variety of forms. Yaryura-Tobias and Neziroglu (1983) described "ideational" and "motor" compulsions. The former being an urge to carry out on act within one's mind (i.e., counting, repeating). The latter being an urge to carry out the performance by muscular participation. Yaryura-

Tobias and Neziroglu (1983) included four subtypes within the "motor" compulsions: (1) aggressive, which is the urge to act out either verbally or physically (i.e., self-mutilation); (2) physiological (i.e., defecation, urination, eating, drinking); (3) movement (i.e., touching, tics, clapping, exercising); (4) ceremonial, which is related to acts of purification (i.e., hand washing, showering, cleaning), or related to fear of germs and/or feelings of dirtiness. Magical thinking and superstitions are often involved.

Steketee (1993) described the forms of compulsions that are more familiar. The most common forms of compulsions are washing and checking. Washing rituals are designed to remove contamination from a specific source (i.e., germs, chemicals). The individual fears some general or specific consequence of contamination (i.e., ill, dying, or causing someone else to do so). The fears expressed are often exaggerated versions of normal concerns (i.e., AIDS, pesticides).

The situations that are checked are directly related to the obsessive fears. For example, if the person fears that someone will break into the house, they must check the doors and windows over and over.

"Repeating" involves superstitions in which ordinary acts (e.g., touching something, sitting down and getting up, crossing a threshold) are repeated to prevent an imagined disaster.

"Ordering" is the arrangement of objects to produce a satisfying symmetry or balance. This is often done to alleviate a general feeling of discomfort or dread rather than to prevent a particular catastrophe.

"Hoarding" is excessive collecting or saving. This compulsion serves to prevent the loss of potentially important objects or information. The saved items often include written information (e.g., newspapers, magazines, bills, etc.).

Another illusory form of a compulsion is the repeated requests for reassurance of "experts" or family members. For example, calling poison control over and over, repeatedly asking whether an object is "safe " to touch, and asking for repetition of a statement or instructions to ensure correct understanding (Steketee, 1993).

A rare category of OCD is "obsessional slowness." An example is daily grooming carried out with such meticulous care that it requires hours of effort. "Since such behaviors are not usually associated with anxiety or other negative emotional states, they appear to be an atypical form of OCD" (Steketee, 1993, p. 10).

Ammerman (1993) explained that if the compulsion is interrupted prior to completion, the patient will feel forced to begin the ritual again in order to neutralize the original obsession. This makes it evident how these

compulsions can consume hours of a patient's time and have debilitating effects.

Washers and Checkers

Gibbs and Oltmanns (1995) and Rachman and Hodgson (1980) looked specifically at differences among washers and checkers. According to the authors, washers' fears are triggered more often by external cues. The washing ritual is viewed as a form of passive avoidance designed to mimic anxiety by restoring their environment to a state of safety. The obsessive-compulsive washer fears contact with circumscribed objects or situations. On the other hand, checkers are concerned with future harm. Checking rituals are viewed as a form of active avoidance that is related to the fear of criticism and focuses on issues of responsibility. Checking behaviors are distinguished from other compulsions in that they are usually oriented toward the future and are preventative in nature, with a central fear component revolving around thoughts of disaster.

According to Gibbs and Oltmanns (1995), "Both the form and the content of obsessive-compulsive symptoms can differ dramatically from patient to patient, as well as with a single patient across time" (p. 183). Gibbs and Oltmanns (1995) further explained that obsessive-compulsive washers tend to have acute onset with a clear precipitating factor, with

onset occurring later than the average onset of OCD. Washers tend to be female, married, and employed in unskilled vocations (Gibbs & Oltmanns, 1995: Rasmussen & Eison, 1992). On the other hand, checkers tend to be single, and male with a younger age of onset, which is not usually associated with any distinct precipitating factor (Gibbs & Oltmanns, 1995; Rachman & Hodgson, 1980; Remussen & Eison, 1989). Checkers also tend to be employed in professional vocations.

Rachman and Hodgson (1980) identified an additional sharp contrast among washers and checkers. A checker's obsessions often take the form of doubts and convictions, and the content of the obsession is focused on daily activities. Washer's obsessions are manifested as fears and the content is focused on dirt, religion, and illness.

Behavioral Model

There are two principal schools of thought that attempt to explain the cause and the progression of OCD. The first is the behavioral model, and within this model there are four somewhat different explanations. Emmelkamp (1982) suggested that a traumatic event usually marks the beginning of onset of OCD. "Analysis of patient history's suggests that the onset is gradual without the presence of one or more traumatic events" (Emmelkamp, 1982, p. 23). Furthermore, when an OCD patient is in a

stressful period, ritualistic activities prove to have powerful anxiety reducing effects. In other words, according to Emmelkamp's behavioral model, the stored representation of past events are activated at the time of a stressful life experience.

Barlow (1985) suggested that first a neutral event becomes associated with fear by being paired with a stimulus that by its nature provokes discomfort or anxiety. Through an association process, concrete objects as well as thoughts and images acquire the ability to produce anxiety. Escape or avoidance responses are developed to reduce anxiety provoked by various conditioned stimuli and are maintained by their success in doing so (Barlow, 1985; Steketee, 1994). "Passive avoidance behaviors are ineffective therefore, active avoidance patterns in the form of ritualistic behaviors are developed" (Barlow 1985, p. 73)

Ammerman's (1993) behavioral conceptualization of OCD stems from Mowrer's two-stage theory of fear and avoidance, developed in 1939. In stage one classical conditioning is involved in conditioning fear to a previously neutral stimulus. The second stage involves operant conditioning via escape from the feared stimulus and later complete avoidance. When Mowrer's theory is applied to OCD, obsessions are viewed as classically conditioned to produce anxiety, which is reduced by

compulsive rituals. The neutral object or thought becomes associated with fear or anxiety by being paired with a traumatic stimulus that provokes discomfort. Escape and avoidance of the feared object or internal events are negatively reinforced by the reduction in anxiety. "Because many cues for obsessive fear cannot by avoided easily (e.g., using bathrooms, locking doors), passive avoidance is often ineffective in controlling anxiety and active compulsions are employed to prevent harm or restore a feeling of safety" (Steketee, 1994, p. 615).

Ammerman (1993) made a distinction between "active" and "passive" avoidance. Passive avoidance is when the individual avoids situations that might provoke discomfort. Active avoidance is the performance of an activity designed to reduce discomfort (p. 167). "Clearly, while behavioral formulations have contributed substantially to the successful treatment of OCD, there is much remaining to be discovered about behavioral and cognitive learning processes that initiate and maintain this disorder" (Ammerman, 1994, p. 168). Steketee (1994) pointed out that Foa and Kozak (1986) and Rachman (1993) included other modes of acquisition, such as observation (modeling) or informational learning because many patients cannot recall specific conditioning events associated with symptom onset.

Cognitive Model

The first attempt to conceptualize OCD in the cognitive model was by Carr in 1974 (van Oppen & Arntz, 1994). Carr emphasized unrealistic threat appraisals in OCD. "This threat appraisal is an individual's evaluation of a situation in terms of its harmful implications" (van Oppen & Arntz, 1994, p. 80). Obsessive-compulsives experience a high degree of threat in which they overestimate both the probability and the cost of the occurrence of undesirable outcomes. This is supported by findings that obsessive-compulsives are more cautious of getting involved in risk-taking activities versus other psychiatric patients (Farid, 1986; Steketee & Foa, 1985). Carr (in van Oppen & Arntz, 1994) assumed that a threat is some multiplicative function of the subjective cost of an event and its subjective probability. Because of the high subjective estimate of the probability of the undesirable outcome, a number of situations will lead to a high level of anxiety; obsessive-compulsive rituals are developed in order to lower the subjective probability of the unfavorable outcome. In other words, the obsessive-compulsive rituals serve the purpose of threat reduction. It remains unclear why obsessive-compulsive patients have high subjective estimates of the probability of unfavorable events and of the subjective costs.

McFall and Wollersheim (in van Oppen & Arntz, 1994) based their cognitive theory of OCD on Carr, but with a slightly different angle. McFall and Wollersheim emphasized factors which influence the unrealistic subjective estimate of catastrophic outcomes. They postulate that cognitions have a mediating role in the performance of compulsions. "The threat is generated by an immediate cognitive, primary appraisal process whereby the individual estimates the danger of an event relative to the perceived resources to cope with it" (van Oppen & Arntz, 1994, p. 80). The primary appraisal of threat results in anxiety by which the obsessive-compulsive behavior is initiated on the basis of the secondary appraisal of the likely consequences of his/her efforts to cope with the threat.

Unreasonable beliefs influence the primary appraisal. These unreasonable beliefs tend to be; (1) one should be perfect; (2) making mistakes results in punishment; (3) one is powerful enough to initiate/prevent the occurrence of disastrous outcomes; (4) certain thoughts and feelings are unacceptable and could lead to a catastrophe (van Oppen & Artnz, 1994). There are also unreasonable beliefs that influence the secondary appraisal; (1) if something is or may be dangerous, one should by terribly upset by it; (2) magical rituals or obsessional ruminations will circumvent feared outcomes; (3) it is easier and more effective to carry out

a magical ritual or to obsess than it is to control one's feelings/thoughts directly; (4) feelings of uncertainty and loss of control are intolerable, should make one afraid, and something must be done about them (van Oppen & Arntz, 1994). In light of McFall and Wollersheim's work they were unable to distinguish between threat appraisals in obsessive-compulsives and in other patients.

Salkovskis (1985) is perhaps the most well known cognitive theorist when it comes to OCD. His model is based on the same model of emotions used in the cognitive model of Beck for depression and anxiety. "The central theme is that the idea, not an event, but rather people's interpretation of an event, leads to a specific emotional response" (Salkovskis, 1985, p. 572). The response to particular stimuli occurs as a result of negative automatic thoughts. Salkovskis (1985) emphasized the difference between intrusions and automatic thoughts. Negative automatic thoughts are relatively autonomous and idiosyncratic, experienced as reasonable and egosyntonic. On the other hand, obsessions, which are intrusive thoughts that evoke negative automatic thoughts, lead to neutralizing by the obsessive-compulsive person.

As a result of the neutralizing activity, intrusive thoughts become more salient and frequent and they evoke more discomfort which increases

the probability of more neutralizing activity. Neutralizing is an attempt to put things right and avert the possibility of being blamed by self or others. Negative automatic thoughts of obsessive-compulsives are related to ideas of personal responsibility. Salkovskis (1985) argued that if the appraisal does not include an element of responsibility, the person is likely to be anxious or depressed rather than having an obsessional problem. Rheume et al. (1995) expanded on Salkovskis' theory by explaining that we all rely on cognitive strategies to reduce the torrent of incoming data to a manageable stream, but that for someone with an anxiety disorder, these strategies may be built upon erroneous propositions and beliefs.

Perceived Responsibility

The importance of cognitive processes is stressed in van Oppen and Arntz's (1994) evaluation of the current cognitive models and in Salkovskis' (1985). The authors stressed the importance of whether or not the obsessive-compulsive person perceives personal responsibility. "When the person believes that he or she should do something in order to prevent or reduce the danger or the perceived personal responsibility this eventually will result in the compulsion" (van Oppen & Arntz, 1994, p. 81).

An excessive sense of responsibility has been identified in OCD where patients evaluate their thoughts in terms of the harm they could

cause to themselves or others (Rachman, 1993; Rheume et al., 1995; Salkovskis, 1985). Responsibility is the belief that one possesses the power to provoke or prevent crucial negative outcomes (Rheume et al., 1995). Salkovskis (1985) placed particular emphasis on responsibility in his cognitive oriented theory of OCD. The work of Freeston, Ladouceur, Thibodeau, and Gagon (1992) and Rheume et al. (1995) has provided support for aspects of that theory. According to Salkovskis (1985), obsessive compulsives associate with dysfunctional cognitive schema for responsibility. In other words, patients evaluate their thoughts in terms of the harm they could do to self or others.

Using Salkovskis' (1985) jargon, different stimuli release cognitive intrusions which provoke automatic thoughts that are evaluated according to personal beliefs. The automatic thoughts provoked by obsessive-compulsives revolve around personal responsibility. Some of the thoughts that are associated with this schema are blame, punishment, guilt, and shame. The perceived responsibility may be direct or indirect and can extend to merely having had the thought itself. In addition, persistent reassurance seeking, particularly from those in authority, is seen as a way of spreading responsibility (Salkovskis, 1985). "Observed responsibility is most readily identified among checkers and less easily identified, but

present among pure obsessives" (Rheume et al., 1995, p. 167). Checkers represent the case where the threat and responsibility schemata are simultaneously present and directly related to the target thought or situation.

According to Lapatka and Rachman (1995), distortions of responsibility play a lesser role in compulsive cleaning behaviors. "Despite treatment recommendations on the need to correct excessive feelings of responsibility, the link between responsibility and compulsions remains obscure" (Ladoucer et al., 1995, p. 938). This is due to the reality that manifestations of responsibility are not always easily identified nor present.

Obsessive-Compulsive Disorder vs. Obsessive-Compulsive Personality Disorder

In the diagnosis of OCD there are problems that may arise for the clinician due to its similarity to Obsessive-Compulsive Personality Disorder (OCPD) and the presence of secondary symptoms. First, a distinction must be made between OCD and OCPD. Several traits of OCPD (e.g., orderliness, rigidity, and perfectionism) have commonly been found in clients with OCD (Yaryura-Tobias & Neziroglu, 1983). According to Yaryura-Tobias and Neziroglu (1983), in OCD the obsessions arouse anxiety and are accompanied by a subjective urge to perform a compulsion

overriding an internal resistance to do so. These symptoms are usually alien to the patient's personality. In OCPD, the obsessions tend not to arouse anxiety and are accepted by the individual. They seldom believe their obsessions and compulsions are unreasonable or absurd nor intolerable, and are not compelled to perform the act nor undo it.

Comorbity

Comorbity in OCD is the rule more than the exception, according to most studies (Barlow et al., 1986; Farid, 1986; Steketee, 1993). This presents a problem for treatment. Anxiety disorders are the most prevalent mood state in OCD, characterized by at least seventy-five percent (Farid, 1986). "Indeed, OCD is classified in DSM IV as an anxiety disorder and is also commonly comorbid with several other anxiety disorders; although such anxiety comorbidity has not been identified as having any prognostic significance thus far" (Steketee, 1993, p. 16).

According to Farid (1986), depressed mood appears to be extremely common, characterizing forty-five percent of patients. Depression seems to follow the onset of OCD symptoms probably due to the debilitating effects of the symptoms. Perhaps more than any other anxiety disorder, OCD is often complicated by depression (Barlow et al., 1986; Steketee & Foa, 1985).

In addition, OCD is often comorbid with personality disorders and psychosis. "From a clinical standpoint, a decade or two ago, it was not uncommon for clients with apparently straightforward `neurotic' OCD symptoms to have received prior diagnosis of schizophrenia" (Steketee, 1993, p. 20). Steketee (1993) went further to suggest that personality tests (e.g., MMPI & Rorschach) and the seemingly peculiar content of the patient's obsessions and compulsions often mislead clinicians. Alcoholism, although not all that likely, typically also follows the reported onset of OCD as self medication for the anxiety (Steketee, 1993).

Due to the perception of danger and responsibility, OCD patients often appear as having characteristics of both anxiety and depressive disorders. "Both OCD and other anxiety disorders involve ruminations about future catastrophic events, however, OCD differs from the other anxiety disorders in perceived responsibility" (van Oppen & Arntz, 1994, p. 82). OCD resembles depression with respect to the personal responsibility for the catastrophic event, but differs from depression on the time dimension. "Reactive depression may occur in OCD due to severe and intense feelings of frustration, as a result of the inability to control symptoms that dominate the patient's life" (Yaryura-Tobias & Neziroglu, 1983, p. 13).

According to Riccardi and McNally (1995), recent comorbidity studies indicate that as many as seventy-five percent of adults with OCD experience major depressive disorder. "Not only do OCD patients often suffer from depressed mood or from full-blown depressive disorder, but their preoccupation with guilt, failure, worthlessness and responsibility also resemble the themes that are characteristic of depressed patients" (van Oppen & Arntz, 1994, p. 81). Subclinical dysphoric states characterized by low self esteem, guilt, exhaustion, and indecisiveness have been observed in OCD patients as well as those with depression (Riccardi & McNally, 1995; Sutherland, Newman, & Rachman, 1982). This often presents a problem for the clinician to make an accurate diagnosis. It is unclear whether the mood disorder is related to the obsessions, compulsions, or both. Theoretical accounts of obsessives propose that depressed mood and other negative mood states increase the vulnerability for obsessions (Sutherland et al., 1982). These findings have been replicated in other studies as well (England & Dickerson, 1980; Riccardi & McNally, 1995).

There are also secondary symptoms that may not be present in every obsessive-compulsive but are observed frequently enough to be considered a very important part of the disorder. According to Yaryura-

Tobias and Neziroglu (1983) they are; (1) anxiety or the fear of a real situation and the uncertainty of its outcome; (2) depression or feelings of sadness, hopelessness, helplessness, and lack of drive (suicide and emotional liability are very common); (3) aggressive behavior whether it be in the form of mental, verbal, or physical; (4) phobia; (5) sexual disturbance or increase/decrease in libido, frigidity, impotence and delayed or premature ejaculation. "These disturbances may be caused by the patient's strict viewpoints on religious and/or moral matters, or the consequence of psychiatric medication" (p. 14). Finally, speech patterns are usually repetitive, circumstantial, circular, and redundant. The quality of speech is characterized by preciseness and good diction.

Steketee (1993) stated, "Several disorders have been likened to OCD and may respond favorably to treatments appropriate for that disorder" (p. 14). Examples of accompanying disorders are; hypochondriasis, anorexia, bulimia, and trichotillomania. Trichotillomania is the feeling or compulsion to pull hair. The hair pulling is typically experienced as pleasurable or satisfying rather than only discomfort reducing. Trichotillomainia, however, lacks the characteristic of obsessive thought.

Assessment

Due to its widely varying symptom manifestations, assessment of OCD can be difficult. According to Steketee (1993), the assessment of OCD requires several methods of gathering information. Clinical interviews are the clinicians primary source of information, followed by behavioral observations and questionnaires. The assessment process should include information about the following: external sources of fear, internal triggers for fears, worries about consequences, amount of passive avoidance behavior, and all forms of active, behavioral, and/or cognitive compulsions (Steketee, 1993; Stoll & Baldessarini, 1992).

The earliest psychological instruments used in diagnosing OCD are the MMPI, the Cornell Health Questionnaire, and the Maudley Personality Inventory (Yaryura-Tobias & Neziroglu, 1983). These instruments all contain several items pertaining to obsessional or perfectionistic traits, but none give an adequate coverage of the wide range of traits that are usually encountered in clinical practice. The Maudsley Obsessional-Compulsive Inventory (MOCI) was developed by Rachman & Hodgson in 1977 and is the instrument used in the study that follows. "Its focus on symptoms to the exclusion of traits has rendered this instrument useful in the assessment of treatment directed at symptoms" (Barlow, 1985, p. 122).

Yaryura-Tobias and Neziroglu (1983) discussed the major

problems associated with the assessment of OCD. First, the multiplicity and wide range of symptoms and disabilities tends to render comprehensive questionnaires that are unwieldy and inflexible. In addition, individual measures tend to be unreliable between patients or studies. Second, the complex relationship with both anxiety and depression contaminates results of treatment, especially treatment with antidepressants, and also contaminates assessment measures. Finally, the rarity of patients with obsessional neurosis account for one to three percent of new outpatient attendances, which means that it is unlikely that single center studies could accumulate sufficient patients for randomization in controlled treatment trials.

In conclusion, the aetiology for OCD remains unclear although both early socialization experiences and neurophysiological factors seem to contribute to its development (O'Connor & Robillard, 1995) Parental rearing style, in particular, dimensions of parental affection and parental control have been associated with OCD (O'Connor & Robillard, 1995). Between 1985 and 1986 the OCD Foundation, a national referral network and information clearinghouse based in New Haven, Connecticut was formed. Their outreach efforts have included the formation of OCD self-help and support groups in a number of cities across the country, speakers

for interested organizations, and the distribution of informative literature to numerous hospitals and clinics. Due to the fact that more and more patients are presenting for treatment, more and more subjects are available for study. This makes true experimental research more feasible, less time consuming, and thus more likely to be undertaken.

Due to the complex symptomology of OCD clinicians face a real challenge in effective diagnosis and treatment of the disorder. There is an abundance of research on the development and progression of OCD, but little on gender differences among obsessive-compulsive patients. The purpose of this research is to examine if there are gender differences between compulsive checkers and washers. There have been some studies on gender and other disorders, some of which present themselves with OCD. It may prove to be helpful to research this topic in order to provide more effective treatments and diagnoses, as well as a better understanding of OCD.

Chapter III

Method

Participants

Participants for this research were contacted at a local self-help group for people with OCD and their family and friends. Thirteen men and eighteen women volunteered to participate in this project. The subjects were all caucasian and ranged in age from eighteen to sixty-two. All subjects had an official diagnosis of OCD which was the only requirement for inclusion in the study.

Procedure

Thirty-five members of the self-help group were given the Maudsley Obessional-Compulsive Inventory (MOCI) at the beginning of the group therapy session. They were instructed to take a few minutes at the beginning of the group therapy session to complete the thirty item, true/false questionnaire. Participation in the study was voluntary. The group leader used the inventory as the topic of discussion and provided opprotunity for anyone to ask questions or discuss any of the items on the questionnaire. Thirty-one of the thirty-five group members chose to participate in the study. The completed questionnaires were returned at the end of the session. Each questionnaire was then scored. For the purpose

of this study only the total obsessions, washing and checking scales for men and women were scored.

Instrument

The MOCI is a thirty item, true/false instrument designed by Hodgson and Rachman (1977) to provide a quantitative assessment of the intensity of total obsessions, as well as the intensity of washing, checking, ruminations, slowness-repetition, and doubting-conscientiousness. Since the ruminating component consists of only two items, Hodgson and Rachman (1977) did not provide a score for ruminations.

In order to validate the MOCI, Hodgson and Rachman (1977) compared the scores on two of the subscales (checking & washing) with retrospective therapists ratings of forty-two obsessional patients. "A satisfactory relationship between therapist ratings and questionnaire scores was found" (Hodgson & Rachman, 1977, p. 391). Therefore, patients who were categorized as checkers or washers on the basis of their questionnaire were usually assigned to the respective category by the therapist. In addition, concurrent validity was assessed by comparing total MOCI scores with Leyton Obsessional Inventory scores for thirty obsessional patients. The correlation was found to be .60 (Emmelkamp, 1982). Test-retest reliability of the total score was determined by using

fifty night-school students, who were given the questionniare on two occasions, one month apart. "The test-retest reliability may be questioned, because it was determined on fifty night-school students rather than on an obsessive-compulsive group, whose reliability might have been quite different" (Steketee & Foa, 1985, P. 58). For example, considering that obsessive-compulsive individuals are quite indecisive, their answers may differ on two testing occasions. A coeffecient for test-retest reliability was not given in Steketee and Foa's, (1985) article.

Data Analysis

The thirty-one questionnaires were collected at the end of the group therapy session. The total obsessions, washing, and checking scales were then scored using Rachman and Hodgson's (1977) scoring key. The researcher calculated the mean scores for the total obsessions score by gender. The Pearson chi-square statistic was used to determine if there was a correlation between washing and checking scores, and gender.

Chapter IV

Results

Mean, Median, and Mode

Table 1 presents the mean, median, and mode for the Total Obsessions scores for males and females. The mean score for Total Obsessions by females was 17.0, which was higher than the mean score for males. The mean score for women (17.0) was also higher than the total mean score (15.07), whereas the mean score for men (12.38) was lower for Total Obsessions. In other words, the women in this study reported a higher number of compulsions than the men, and the total participants combined.

Table 1

Mean, Median, and Mode for Total Obsessions Scores

	Men	Women	Total
Mean	12.38	17.00	15.07
Median	14.00	18.00	16.00
Mode	18.00	18.00	18.00

Men

Table 2 displays the chi-squared statistic for males and females with either a washing or checking compulsion. The first cell indicates that 6 men were categorized as washers. If the null hypothesis is true, it would be expected that 5.5 men would be categorized a washers. The residual, .5, is the difference between the observed and expected frequencies. A residual with a positive sign indicates that more cases were observed than were expected if the null hypothesis is true. On the other hand, 7 men were categorized as checkers. If the null hypothesis is true, it would be expected that 7.5 men would be categorized as checkers. The residual, -.5, is the difference between these two numbers (7 and 7.5). A negative residual indicates that fewer cases were observed than expected.

Women

Seven women were categorized as washers. If the null hypothesis is true, it would be expectd that 7.5 women would be categorized as washers. The residual, -.5, indicates that fewer cases were observed than expected. Eleven women were categorized as checkers. If the null hypothesis is true, it would be expected that 10.5 women would be categorized as checkers. The residual, .5, indicates that more cases were observed than were expected.

Table 2

Pearson Chi-Square Statistics for Gender by Compulsion Type

		Washer	Checker	Row Total
Male	observed	**6**	**7**	13
	expected	**5.5**	**7.5**	41.9%
	residual	**0.5**	**-0.5**	
Female	observed	**7**	**11**	18
	expected	**7.5**	**10.5**	58.1%
	residual	**-0.5**	**0.5**	
Column		13	18	31
Total		41.9%	58.1%	100.0%

Chi-Square	**Value**	**DF**	**Significance**
Pearson	**.1636**	**1**	**0.6859**

Pearson Chi Square

The observed significance level for a chi square of .1636 for a table that has two rows and two columns is 0.686. A discrepency this small between the observed and expected frequencies would occur 68.6% of the time in the population. This indicates that men and women with OCD, in this study, equally had washing and checking compulsions. Since the observed significance was quite large, the null hypothesis was accepted. The variables gender and cumpulsion type are independent.

Chapter V

Discussion

Results

The relatively high mean scores for the total obsessions scale indicate the chronic and debiliating nature of OCD. "The obsessions appear in an intrusive manner, usually gradually and invasively" (Yaryura-Tobias & Neziroglu, 1983, p.10). The obsessions are endless and nonmotivated.

The compulsions are clearly excessive and consume hours of a patient's time (Ammerman, 1993; DSM IV, 1994). If the compulsion is interrupted prior to completion, the patient will feel forced to begin the ritual again in order to neutralize the original obsession (Ammerman, 1993). For example, if a compulsive checker must check all of the doors and windows ten times before they can leave the house, and they are interrupted during the eighth time through their routine, the obsessive-compulsive checker must start over in order to neutralize the severe anxiety.

This leads to the fact that comorbity in OCD is the rule more than the exception (Barlow et al., 1986; Farid, 1986; Steketee, 1993). According to the above researchers, obsessive-compulsives often present

themselves to clinicians with secondary symptoms of depression, personality disorders, or alcoholism. This may due to the debilitating nature of the disorder, or the frustration experienced due to an inablity to control the symptoms. The varying manifestations of symptoms and the presence of secondary disorders not only makes assessment , but treatment of OCD difficult and challenging.

Limitations

Some researchers claimed that more women with OCD reported washing compulsions, and men with OCD reported checking compulsions (Ammerman, 1993; Yaryura-Tobias & Neziroglu, 1983). According to this study, an equal number of men (7) and women (7) reported checking compulsions, with more women (11) reporting checking compulsions. This may have been due to the small sample size obtained for this study. A larger umber of participants in this study may have supported Ammerman's (1993) and Yaryura-Tobias' and Neziroglu's (1983) claim.

In addition, the observed significance level for the chi-square statistic tends to decrease with larger sample sizes. In other words, if the sample size contained 100 participants instead of 31 participants, gender differences among the compulsion types may have been more evident. Unfortunately, due to a lack of support for this research project by local

symptoms. For example, a female with washing compulsions may need a different treatment approach then a male with washing compulsions. The same may hold true for males and females with checking compulsions.

Due to an increased public awareness about OCD, the families and friends of OCD sufferers, and even the patients themselves, are often the first to recognize the condition. "More often than not, the patients themselves are self-diagnosing and self-referring for treatment" (Riccardi in Stoll & Baldessarini, 1992, p. 639). Consequently, with more obsessive-compulsives presenting themselves for treatment there will be more subjects available for research in the area of gender.

Appendix A

Diagnostic Criteria for Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:

Obsessions are defined by (1), (2), (3), and (4):

(1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems

(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action

(4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):

(1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.

(2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note**: This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal

routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis 1 disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:

With Poor Insight: if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable.

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