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OBSESSIVE COMPULSIVE NEUROSIS IN NORTH-WEST INDIA
A phenomenological study*

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SUMMARY

Seventy two patients fulfilling Research Diagnostic Criteria for obsessional illness were studied in detail from a phenomenological point of view. Frequency of various forms and contents of obsessions and compulsions were delineated. The forms of obsessions seen were ; doubts (65 %) ; thinking (52.7 %) ; fear (47.2 %) ; magical thinking (36.1 %) ; impulse (4.1 %) ; image (4.1 %) and others (5.5 %). In compulsions, yielding compulsions were most common being present in 59.7 % of the cases. Analysis of the content of the obsessions revealed that dirt and contamination was the commonest content (48.3 %).

The concept of an obsessional illness has been with us for quite sometime. The psychiatric use of the word "obsessional" is closely related to its usual dictionary meaning as being harassed, preoccupied or haunted by a thought or idea. Almost every definition implies that repetition, unpleasantness and undesirable nature of the thought are the inherent qualities of an obsession.

It is generally accepted that obsessive compulsive neurosis (OCN) is an uncommon disorder. Because of the relative rarity of the disorder and paucity of published studies, the natural history and phenomenology of OCN have not been investigated in detail and only few research workers have attempted to describe this puzzling disorder from a phenomenological point of view (Ingram 1961, Kringlen 1965, Akhtar et al 1975, Manchanda and Sethi 1978).

The present study aims to provide a detailed and comprehensive account of the phenomology of OCN and also attempts to substantiate earlier reports.

Material and Methods

The patient sample for the study was selected from patients attending the psychiatric out-patient clinic of Nehru Hospital, Postgraduate Institute of Medical Education and Research, Chandigarh which serves a broad area of the North-West of India. The case records of all the patients seen in the clinic between 1st Jan, 1981 and 31st Dec. 1982 were subjected to perusal and those case records in which diagnosis of OCN coded as 300.3 of ICD-9 (WHO 1978) was entered as the final diagnosis were subjected to further detailed investigation.

Employing Research Diagnostic Criteria (RDC) for the diagnosis of OCN (Spitzer et al 1978), further assessment of the history of the disorder and its manifest psychopathology was done. A total of 72 cases were thus identified which fulfilled RDC for the diagnosis of OCN.

For the present investigation, the manifest psychopathology for the purpose of phenomenology was operationally divided and defined as follows;

A: *Forms of Obsessions:*

a) *Obsessive doubt:* a lingering inclina-

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tion not to believe that a task has been satisfactorily accomplished.

b) *Obsessive thinking:* Thoughts which repeatedly intrude into conscious awareness, interfere with normal train of thought and cause distress to the patient and/or prolonged inconclusive thinking about a subject usually pertaining to future.

c) *Obsessive magical thinking:* idea which is based on a magic formula of thought equals i.e. a thought equals an act, harm or suffering to self or others.

d) *Obsessive fear:* a fear of losing control and thus an apprehension of committing a socially embarrassing act.

e) *Obsessive impulse:* a powerful urge to carry out actions which may be trivial or socially distruptive or assaultive.

f) *Obsessive image:* Persistence before mind's eye of something seen or images of violent, sexual or disgusting nature that come repeatedly into mind.

g) *Miscellaneous:* when the phenomenon was obsessional in nature but could not be classified into any of the six forms mentioned above.

B: *Forms of Compulsions:*

a) *Yielding compulsion:* a compulsive act that gives expression to the underlying obsessive urge.

b) *Controlling compulsion:* a compulsive act which tends to ward off and divert the underlying obsession without giving expression to it.

C: *Content of obsessions:*

a) *Dirt and contamination:* dirt, dust, menstrual blood, human or animal excreta, other excretion of the body, germs, bacteria, virus etc.

b) *Inanimate and impersonal:* Mathematical figures, orderliness in arrangement or performance of certain tasks, locks, bolts, mechanical or electronic devices etc.

c) *Sex:* sexual advances towards self or others, incest, masturbation, sexual competance etc.

d) *Religion:* existence of God, religious practices, mythological stories etc.

e) *Aggression:* Physical or verbal assault on self or others, accidents, deaths, wars, mishaps, natural calamities etc.

f) *Miscellaneous:* Not classifiable in any of the above mentioned categories.

The information about the frequency of occurrence of various forms of obsessions and compulsions and the content of obsessions was abstracted from the case notes. In 52 patients who were on regular follow-up or came to the clinic at our request, this information was supplemented by clinical interviews with the patients and the relatives of the patient.

Results

The results are shown in the Table, where it can be seen that obsessive doubts is the most frequently encountered phenomenon being present in 65.2 per cent of the cases. Yielding compulsions were the

commonest type of compulsion seen in 59.7 per cent. Analysis of content of obsessions shows significant differences between the two sexes.

It must be mentioned that majority of patients had more than one obsession and only 11 cases had only one obsession.

Obsessive thinking was present in 52.7 per cent of cases. Akhtar et al (1975) disproved usage of "obsessive rumination" as a term to describe a form of obsession, claiming that rumination is central to most, if not all, obsessive thoughts and ideas. Manchanda and Sethi (1978), however, used the term "obsessive rumination" to describe

Table
Phenomenological characteristics of the OCN patients

Phenomenology	Male	Female	Percentage of the total
I: Forms of Obsessions			
Thinking	21	17	52.7
Doubt	25	22	65.2
Fear	21	13	47.2
Impulse	3	0	4.1
Image	3	2	4.1
Magical thinking	15	11	36.1
Miscellaneous	4	0	5.5
II: Forms of Compulsions			
Yielding	24	19	59.7
Controlling	2	3	6.9
Both yielding and controlling	7	4	15.2
None	8	5	18.0
III: Content of Obsessions			
Dirt and contamination	12	19	48.3*
Inanimate and impersonal	16	13	44.6*
Sex	14	3	23.1*
Religion	4	3	9.8*
Aggression	5	1	8.4*
Miscellaneous	2	1	4.2*

* Significant at 0.05 level (Chi square Test)

Discussion

As regards the form of obsession, doubt of an obsessive nature is the most frequently reported phenomenon being present in 65.2 per cent of the cases. Most often these doubts were regarding cleanliness or orderliness. Our findings in this respect are in agreement with the observations of many authors (Lazare et al 1966, Salzman et al 1968, Akhtar et al 1975, Manchanda and Sethi 1978).

"obsessive thinking". We feel that most obsessive ideas and thoughts have a ruminative quality, as such the term "rumination" does not serve any specific or useful purpose. Therefore, we have discarded this term in favour of "obsessive thinking".

It must be pointed out that very few patients had only one form of obsession (N = 11), many patients had more than one form of obsessions, the commonest being a combination of obsessive doubt and obsessive

thinking which was seen in 82 per cent of the patients with multiple obsessions. In 4 patients, obsessive fear was associated with obsessive thinking. Manchanda and Sethi (1978) have also commented on patients having more than one form of obsessions.

Obsessive fear was seen in 47.2 per cent of the cases. In an obsessional patient, the obsessive fear is of losing self control and unintentionally indulging in socially embarrassing or trivial acts. Unlike phobia, where the phobic stimuli are externalized or exist in the environment, in obsessive fear, the so called phobic stimuli are internalized and introspected; these force themselves on the conscious awareness of the patients and cannot be banished. Obsessive fears are often associated with elaborate, overwhelming and intrusive compulsions and magical thinking; simple phobics are devoid of these qualities (Kraüpl Taylor 1983), Marks et al (1969) have pointed out that most phobias respond to desensitization but such is not the case with obsessive fears.

Obsessive image and obsessive impulse are relatively rare forms of obsessional symptoms. These are very infrequently encountered and this finding is in agreement with that of Akhtar et al (1975) and Manchanda and Sethi (1978).

Obsessive magical thinking was displayed by 31.1 per cent of the cases. This is an interesting finding and has not been observed or commented upon by many workers in the context of phenomenology or clinical psychopathology. Of the published studies, only Manchanda and Sethi (1978) make reference to this phenomenon but they used the term "obsessive convictions". Central to the theme of "obsessive magical thinking" or "obsessive conviction" is the concept of thought equals or omnipotence of the thought. The patient feels that merely by thought the patient can bring about action. Many patients describe that by merely thinking about a particular subject, person or event they can make it happen or cause harm and suffering. This of course is not a conviction in the true sense of the word but has all the hallmark of an obsession. We, therefore, feel that "obsessive magical thinking" is a better descriptive term than "obsessive conviction" which is a paradox in itself and is perhaps misleading. The literature on the phenomenology of obsessions is rather silent on this curious subject though magical thinking in obsessional patients is well recognized in psychoanalytical literature (Fenichel 1934, Abraham 1942, Freud 1952, Freud 1955, Jones 1950). This phenomenon, as seen in the patients, requires further investigation.

Analysis of the content of obsessions in the two sexes brought out certain significant differences. Preoccupation with dirt and contamination was evidenced with more frequency in females whereas males displayed more obsessive preoccupation with aggression, sex and inanimate/impersonal themes. Except Lewis (1936), other workers from other parts of the globe like Pollitt (1957), Ingram (1961), Kringlen (1965) and Lo (1967) have not commented on this aspect of the content of obsessions. Chakraborty and Banerji (1975) observed that Bengali Society has strong socio-cultural sanctions and commented on the relationship of "Suchi-bai" with the Bengali culture. Manchanda and Sethi (1978) have also commented that the Indian culture as a whole places great emphasis on purity. It is generally accepted that in our culture, females have a predominantly domestic orientation and more religious inclination. This may partly explain the excess of preoccupation with themes of dirt and contamination seen in our female patients.

Sexual and blasphemous thoughts were reported with marked feelings of guilt. Aggressive thoughts were mostly regarding homicide or causing physical harm.

Compulsions were present in 82 per cent of the patients. Yielding compulsions were more frequent being present in 59.7 per cent of the patients. This finding is in agreement with those reported in the literature (Akhtar et al 1975, Manchand and Sethi 1978). Patients reported that by indulging in compulsive acts they got relief though only for a short time. This relief was greater in yielding compulsions as compared with controlling compulsions in patients having both types of compulsions.

The present study is reported from Chandigarh and so was the study of Akhtar et al (1975). Manchanda and Sethi (1978) reported their study from Lucknow. All these studies are from the Northern Part of India. Only one study on phenomenology of OCN is available from Eastern India (Chakraborty and Banerji 1975). There are no reports available from the Southern parts of India. It is quite likely, though speculative, that cultural and religious diversities may result in different form or contents of the phenomena seen in OCN patients.

Perfectionistic and ritualistic behavioural patterns of various types enter in our day to day life in great many ways. In our socio-cultural milieu, many of these are regarded as norms. Varma (1982) has discussed in detail the cultural defence value of various rituals. It is quite likely that these cultural defenses probably prevent the genesis and development of obsessional neurosis in our culture. To delineate the role of culture in the pathogenesis of OCN would require transcultural studies. For the present it does not appear that the phenomenology of OCN has changed much in the last ten years or so.

References

ABRAHAM, K. (1942), Contributions to the theory of anal character. In selected papers. London: Hogarth Press.

AKTHAR, S., WIG, N. N., VARMA, V. K., PERSHAD, D. & VERMA, S. K. (1975), A phenomenological analysis of symptoms in Obsessive Compulsive Neurosis, *British Journal of Psychiatry*, 127, 342-347.

CHAKRABORTY, A. & BANERJI, G. (1975), Ritual, a culture specific neurosis, and obsession states in Bengali culture, *Indian Journal of Psychiatry*, 17, 273-280.

FENICHEL, O. (1934), Outline of clinical Psychoanalysis, New York: Norton.

FREUD, S. (1952), The neuro-psychosis of defence. Complete Psychological works of Sigmund Freud. Vol. 3, London: Hogarth Press.

FREUD, S. (1955), Notes upon a case of obsessional neurosis. Complete Psychological works of Sigmund Freud, Vol. 10, London: Hogarth press.

INGRAM, I. M. (1961), Obsessional illness in a mental hospital, *Journal of Mental Science*, 107, 382-388.

JONES, (1950), Anal-Erotic character traits. Papers on psychoanalysis London: Baltiere Tindall and Cox.

KRINGLEN, E. (1965), Obsessional neurotics – a long term follow-up, *British Journal of psyciatry*, 111, 709-715.

KRAÜPAL TAYLOR, F. (1983), Descriptive and developmental phenomena: In Hand book of Psychiatry Vol. 1 (Eds. M. Shepherd and O L. Zangwill) Cambridge University Press.

LAZARE, A., KLERMAN, G. L. & ARMOR, D.J. (1966), Oral, obsessive and hysterical pesonality patterns, *Archives of General Psychiatry*, 14, 624-631.

LEWIS, A. (1936), Problems of obsessional illness. Proceedings of the Royal Society of Medicine, 29,325-330.

LO, W. H. (1967), A follow-up study of obsessional neurotics in Hong Kong Chinese, *British Journal of Psychiatry*, 111, 823-832.

MANCHANDA, R. & SETHI, B. B. (1978), Obsessive compulsive neurosis-Phenomenological aspects, *Indian Journal of Psychiatry*, 20, 250-255.

MARKS, I. M., CROWE, E. M., DREWE, E., YOUNG, J. & DEWHURST, W. G. (1969), Obsessive compulsive neurosis in identical twins, *British Journal of Psychiatry*, 115, 991-993.

SALZMAN, L. (1968), The obsessive personality, New York: Science House Inc.

SPITZER, R. L., ENDICOTT, J. & ROBINS, E. (1978) Research Diagnostic criteria (RDC) for a selected group of functional disorders 3rd Edition New York. Biometric Research, *New York State Psychiatric Institute.*

VARMA, V. K. (1982), Towards a theory of cultural defences. In Readings in Trans-cultural Psychiatry (Eds. A Kiev and A. Venkoba Rao) Madras: Higginbothams Ltd.

WORLD HEALTH ORGANIZATION (1978), International classification of Diseases, 9th Revision, Geneva, WHO.