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SCIENCE DIRECT®
Behaviour Research and Therapy 44 (2006) 1537–1543
BEHAVIOUR RESEARCH AND THERAPY
www.elsevier.com/locate/brat

Do obsessional beliefs discriminate OCD without tic patients from OCD with tic and Tourette's syndrome patients?

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Received 19 May 2005; received in revised form 7 November 2005; accepted 10 November 2005

Abstract

There is considerable overlap in symptomatology between Tourette's syndrome (TS) and obsessive–compulsive disorder (OCD). Increased rates of tics are found in OCD and up to 60% obsessive–compulsive symptoms in TS. However, in OCD obsessive–compulsive symptoms are more often anxiety-related and, as a consequence, aimed at anxiety-reduction, whereas in TS these symptoms are more stimulus-bound. Therefore, it is of clinical interest to study whether these phenomenological differences are reflected in differences between dysfunctional cognitions accompanying OC symptoms in OCD with or without tics and TS. Current cognitive theory of OCD ascertains that specific dysfunctional beliefs are important in the etiology and maintenance of OCD. To assess these beliefs, the obsessive–compulsive beliefs questionnaire-87 (OBQ-87) has been developed. In the present study, OBQ-87 scores of OCD patients without tics, OCD with tics, and TS (without OCD) patients were compared to those of normal controls.

Results: OCD without tic patients exhibited higher OBQ-87 scores than TS patients. No differences were found between OCD with or without tic patients on any of the OBQ-87 subscales. These results suggest that: (1) dysfunctional beliefs have no discriminative power with respect to OCD with or without tic patients; (2) the direct relationship between types of OC symptoms and specific dysfunctional beliefs is questionable. Therefore, one can doubt the specificity of cognitive theory of OCD to explain specific OC behavior.

Keywords: Obsessive–compulsive disorder; Tourette's disorder; Dysfunctional beliefs; Cognitive theory

Introduction

In recent years obsessive–compulsive disorder (OCD) has received renewed interest (Hohagen & Berger, 1998). Once considered a rare phenomenon, epidemiological studies have found it to be the fourth most common psychiatric disorder (Myers et al., 1984), with prevalence rates between 1.5% and 3% in the general population, women being slightly more affected than men (Bebbington, 1998; Stein, Ford, Anderson,

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0005-7967/$ - see front matter © 2005 Elsevier Ltd. All rights reserved.
doi:10.1016/j.brat.2005.11.007

& Walker, 1997). A predominant psychological model to understand the symptoms of OCD is the cognitive model (Salkovskis, Forrester, & Richards, 1998). Salkovskis (1999) presents the main tenets of this model as follows: (1) intrusions occur in at least 90% of the general population, (2) the difference between normal intrusive cognitions and obsessional intrusive cognitions lies in the interpretation. (3) For the OCD patient the intrusive cognition is an indication that he is responsible for harm or its prevention. As a consequence of this interpretation, the OCD patient experiences anxiety, discomfort and is engaged in anxiety-neutralizing (compulsive) behavior.

In order to research the obsessional thought process, an international group of prominent OCD researchers has developed a rating scale measuring the various underlying dysfunctional beliefs that lead to the misinterpretation of intrusions (Obsessive Compulsive Cognitions Working Group (OCCWG), 1997). After examination of the relevant literature and existing OCD measures, the obsessive–compulsive beliefs questionnaire-87 (OBQ-87) has been constructed. This is an 87-item questionnaire, with six subscales, measuring belief domains hypothesized to be characteristic of OCD patients. The OCCWG (2001) has found that the OBQ-87 possesses high internal consistency, high test–retest reliability, and moderate correlations with the Padua Inventory-R (Burns, Keortge, Formea, & Sternberger, 1996), a measure of OCD symptoms. Moreover, the OBQ-87 appeared to show good discriminative power, OCD patients scoring higher than both patients with other anxiety disorders and normal controls (OCCWG, 2003; Sica et al., 2004). To reduce the length of the OBQ, and decrease correlations between subscales, factor analytic procedures were used to create a 3-subscale, 44-item version of this questionnaire (OCCWG, 2005).

Tourette's syndrome (TS) is a disorder of childhood onset characterized by simple and/or complex motor and vocal tics (Sheppard & Bradshaw, 1999). Thirty to 50% of TS patients meet the diagnostic criteria for concurrent OCD (Pauls, Raymond, & Robertson, 1991). Furthermore, elevated rates of tics (10–30%), have been found in patients with OCD (Holzer et al., 1994; Zohar et al., 1992). Family research has strongly suggested that OCD should be regarded as a heterogeneous condition (Pauls, Alsobrook, Goodman, Rasmussen, & Leckman, 1995). At least two forms of familial OCD (one tic-related, and the other non-tic-related) have been found. Although tic-free and tic-related OCD might represent etiologically different disorders, the symptoms of TS and OCD are partly overlapping (Cath et al., 2001b; Petter, Richter, & Sandor, 1998). The symptoms of OCD with tic (OCD + tic) patients are intermediate between TS and tic-free OCD (OCD−tic) patients, sharing features from both disorders. Miguel et al. (1995, 1997) have compared intentional repetitive behaviors between TS and OCD patients. They found that the repetitive behaviors in TS patients are (1) more often preceded by sensory phenomena, (2) less accompanied by cognitions, and (3) less anxiety-driven than in OCD−tic patients. Furthermore, there are some subtle differences in symptom patterns between OCD ± tic patients, OCD + tic patients performing more impulse like non anxiety-related behaviors than OCD−tic patients (Miguel et al., 1997; Zohar et al., 1997). Some researchers have even suggested that OCD + tics constitutes a form of TS, instead of being a subtype of OCD (Cath, Spinhoven, Landman, & van Kempen, 2001a; Cath et al., 2001b).

The aim of the present study was to explore whether differences demonstrated between patient groups using other lines of inquiry are also manifested in differences in dysfunctional beliefs. To do so, OBQ-87 (as well as Padua-R) scores of OCD + tic, OCD−tic and TS patients were compared.

Method

Participants and instruments

This experiment involved four groups: (1) OCD−tic patients ($n = 50$), (2) OCD + tic patients ($n = 19$), (3) TS without OCD patients ($n = 18$), and (4) a non-clinical sample ($n = 30$). All patient groups were recruited from the academic outpatient anxiety clinic of GGZ Buitenamstel. The non-clinical control group was selected randomly via the Amsterdam telephone book. In these participants a brief telephone interview was conducted to explain the purpose of the study and to screen on exclusion criteria. Participants aged over 60 were excluded from the control group to match in age to the patient groups. Control group participants with any past or present mental health treatment were excluded as well. Three control participants (7%) were excluded because of old age, and five (11.63%) were excluded because of current and/ or past mental health treatment.