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Overview of Obsessive-Compulsive Disorder, with Emphasis in Forensics Settings and Evaluations

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ABSTRACT

While research on the etiology and symptomology of obsessive-compulsive disorder (OCD) is plentiful, there remains a paucity of discussion about the disorder's relevance in forensic settings. OCD is found to be underdiagnosed and often has high comorbidity rates with other psychiatric conditions (e.g., psychotic disorders and anxiety disorders), exposing a need for further analysis and a richer discussion. The current paper illustrates the disorder's phenomenology, delineates clinical presentation, and highlights the impacts of OCD on an individual's functionality within forensic contexts. Clinical discussion centers on differential diagnosis (comorbidity and diagnostic subtypes categories), neuroanatomy, neuropsychological limitations (e.g., diminished cognitive flexibility, and disinhibition), and a review of treatment options. The forensic discussion superimposes clinical aspects of OCD onto civil and criminal contexts that demand specific considerations based on the setting and the specific type of assessment being completed. Specific civil applications include the impacts of OCD on disability assessment, parental fitness, risk-assessment, and decisional capacities (e.g., testamentary capacity and medical decision-making). Criminal considerations center on OCD as a consideration for the insanity defense and mitigation, as well as its role in violence risk assessments at the time of community reintegration from a forensic hospital. Holistically, the current article provides a breadth of discussion points to assist forensics consultation, guide clinical practice, and proposes areas for future research.

Keywords: obsessive-compulsive disorder, psychosis, risk assessment, disability, differential diagnoses.

Introduction

"I sometimes picture these unfortunates as men and women being pecked to death by predatory birds. The birds are invisible – at least until a psychiatrist who is good, or lucky, or both, sprays them with his version of Luminol and shines the right light on them – but they are nevertheless very real. The wonder is that so many OCDs manage to live productive lives, just the same. They work, they eat (often not enough or too much, it's true), they go to movies, they make love to their girlfriends and boyfriends, their wives and husbands… and all the time those birds are there, clinging to them and pecking away little bits of flesh". – Stephen King, Just After Sunset.

While much has been written about the etiology and behavioral characteristics of Obsessive-Compulsive Disorder (OCD), there is a paucity of discussion about the disorder's relevance in the forensic setting. Experience treating and evaluating patients with OCD in both outpatient and inpatient forensic settings, and in civil and criminal cases, reveals unanswered questions and relevant nuances for the forensic consultant to consider.

This paper aims to bring awareness of OCD and its impact in our field to the forensic consultant. Discussion highlights the impact of OCD as it appears in the forensic setting, illustrates its phenomenology, delineates hallmark clinical presentation, and exposes the impacts on behavior and functionality. Furthermore, the current paper may guide the forensic consultant to main areas and ways in which OCD can present in forensic settings. Lastly, the current paper explores the relationship between OCD and different types of assessments including disability, criminal responsibility, risk assessment, mitigation, and treatment.

Obsessive-Compulsive Disorder (OCD) is a psychiatric disorder characterized by the presence of obsessions, compulsions, or both. Obsessions are intrusive, repetitive, distressing thoughts, while compulsions are ritualistic acts that are performed to neutralize obsessions[1]. Obsessions and compulsions consume excessive amounts of time, cause significant distress, interfere with everyday functioning, and often impair social relationships. Data from the National Comorbidity Survey Replication (NCS-R) indicates that the typical person with OCD spends about 8.9 years with the disorder and experiences significant functional impairment across multiple areas of their life. Additionally, the same research suggests that loved ones are often involved in the patient's compulsions, either agreeing, enabling, or assisting in carrying out compulsive rituals. Further, the family's quality of life compared to the general population was demonstrated to be significantly lower across physical health (e.g. poor sleep, somatic symptoms of depression), psychological well-being (i.e. more negative feelings), and social relationships.

Though highly comorbid with other psychiatric disorders, OCD is infrequently diagnosed in the forensic setting. Hasler et al. (2005)[2] revealed that in their sample of 317 individuals with OCD, 92% had at least one additional psychiatric condition that varied according to presenting OCD cluster symptoms. As described by Bear (1994),[3] OCD symptoms fall into three general clusters: cluster one included aggressive, sexual, religious, and somatic obsessions with checking compulsions; cluster two included obsessions and compulsions related to ordering, arranging, and symmetry; and cluster three included contamination and cleaning obsessions and compulsions. Hasler et al. (2005) found that comorbid depression and anxiety were associated with symptoms in clusters one and two, comorbid bipolar disorder with cluster two symptoms, and that eating disorders were associated with cluster three symptoms. Additional studies[4] have investigated and established a genetic parallel found in individuals with a familial pattern of OCD and certain comorbidities (anxiety, panic disorder, agoraphobia, and major depressive disorder); yet non-familial OCD was correlated with bipolar disorder and substance use disorders. More severe cases of OCD had higher comorbidity rates and were more likely to have a genetic basis. Furthermore, when OCD is complicated by comorbidity, the obsessive-compulsive symptoms appear to be more resistant to treatment[5].

Despite high comorbidity rates and related complications, OCD continues to present diagnostic challenges that result in delayed diagnosis[6] and treatment[7]. One important consideration is underdiagnosing by mental health providers. For example, Booth et al[8] studied a university medical center, in which 42 of the 1,317 patients with OCD had obsessions of infanticide. Of the 42 patients, only 7 received a diagnosis of OCD. Researchers provided the psychiatrists and residents a case study of a man who met all formal diagnostic criteria for OCD; the defining characteristics were obsessions related to murdering his wife and daughter. Results indicated that only half of the staff psychiatrists and residents identified OCD as their primary diagnosis. In a second case study of catathymic infanticide[9], the patient was diagnosed with major depressive disorder and OCD. the patient contemplated killing his sons early in life so their innocence would "take them to heaven." His diagnosis was later changed to schizoaffective disorder, and a personality disorder was newly diagnosed. This case clearly exemplifies the challenge in differentiation between presenting symptom constellations.

The high comorbidity rates of OCD with other psychiatric conditions coupled with the underdiagnosing of OCD exposes the need for additional analysis and discussion of the potential implications of these findings. The current article provides a brief review of diagnostic criteria, explores the differential diagnosis of OCD, and discusses the relevance of these issues in a forensic context. We discuss implications of OCD in both civil and criminal contents and suggest areas of future research pertinent to assessment and interventions. Finally, we call attention to the need for greater discussion amongst forensic evaluators about the importance of OCD in this context.

Understanding OCD

CATEGORIZATION OF CLINICAL PRESENTATION OF OCD

Psychiatric diagnoses evolve to include the continuous influx of research, clinical experience, and knowledge that the mental health community generates over time. This is most evident in the progression to the DSM-5-TR and the International Classification of Diseases Eleventh Edition (ICD-11), which reflect the most recent conceptualization of psychiatric disorders. The primary change in OCD classification from The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) to the DSM-5, and its most recent edition, DSM5-TR, is a movement from OCD as an anxiety disorder to a separate class called "Obsessive Compulsive and Related Disorders." This class includes obsessive-compulsive disorder, excoriation disorder (skin-picking), hoarding disorder, body dysmorphic disorder, and trichotillomania.

The DSM-5-TR suggests four "themes" or "dimensions" of OCD rather than specific types:

1. Cleaning (e.g., contamination obsessions and cleaning compulsions)
2. Symmetry (e.g., sympatric obsessions and repeating, ordering, and counting compositions)
3. Forbidden or taboo thoughts (e.g., aggressive, sexual, or religious obsessions and related compulsions)
4. Harm (e.g., fears of harm to self or others and checking compulsions)

These themes occur if consistently throughout the duration of the illness, and across cultures. Most notably, patients may experience symptoms across multiple themes. The DSM-5-TR also calls for specification of whether OCD is present with good or fair insight, poor insight, or absent insight/delusional beliefs (in which the patient is completely convinced the beliefs are true), as well as whether the OCD is tic-related.

Beyond the themes currently incorporated into the DSM-5-TR, other common OCD themes relevant to forensic evaluations include religious scrupulosity (e.g., fear of violating moral or religious dictates, fear of being condemned to Hell); confessional (e.g., compulsive confession of perceived or imagined transgressions which the person may have potentially incurred in); and existential (e.g., persistent questions on what is real and not, and the general reality in which the individual exists). The theme of harm may manifest with very distressing thoughts or fears of, for example, having run over a person while driving (with a compulsion to retrace the driving route to ensure that didn't occur); fear of sexually assaulting a non-consenting person or engaging in sexual behavior with children (i.e., pedophilia OCD), or of having an alternative sexual preference; or of maiming or murdering a potential victim, often with an associated method of doing so. The impact of these symptoms on understandings of wrongfulness, voluntary confessions, and reality testing are of particular interest in the forensic setting.

The Yale-Brown Obsessive Compulsive Scale (Y-BOCS)[10] is a widely used, 10-item clinician administered rating scale used to assess OCD symptoms. It delineates dimensions of obsessions (such as aggressive, contamination, sexual, hoarding/saving, religious scrupulosity, symmetry, somatic, and miscellaneous); and compulsions (cleaning/washing, checking, repeating, counting, ordering/arranging, hoarding/collecting, and miscellaneous), with multiple examples or manifestations of each. It allows for a quantification of obsessions and compulsions separately and in totality and allows for periodic reassessment of variability in severity. More recently, the Dimensional Obsessive-Compulsive Scale[11], a 20-item measure that assesses the four main dimensions of OCD symptoms, has also been developed and validated.

DIAGNOSTIC CONSIDERATIONS DIFFERENTIAL DIAGNOSIS OF OCD AND PSYCHOSIS

In practice, the accurate diagnosis of OCD may be hindered by a patient's reluctance to fully disclose symptoms due to shame, fear, or difficulty in accurately describing symptoms with sufficient precision to quantify frequency, duration, impact, etc. OCD may co-occur with psychotic disorders such as schizophrenia, but determination of co-occurrence or differential diagnosis can prove equally complex. Though OCD can present with earlier manifestations of associated disorders such as Tourette's, both schizophrenia and OCD may present starting in early childhood, close to the latency period of development. Both disorders present with behaviors that may appear idiosyncratic, bizarre, disorganized, or purposeless. This is especially true with children, who may not be able to verbalize the connection between intrusive thoughts and compulsions engaged in for anxious relief. Further, both disorders often lead to social isolation, difficulty relating to others, and diminished academic performance.

Differentiating obsessions from command auditory hallucinations can be challenging even for the seasoned clinician seeking diagnostic clarity in patients with overlapping symptoms. Engagement in behaviors can mimic impairments in impulse control associated with schizophrenia, versus impulsivity derived from chronic distress or affective violence in the context of chronic and severe illness or compulsions. With the incorporation of specifiers that include poor or absent insight in OCD, distinguishing from delusional beliefs would warrant very careful exploration[12] - perhaps presenting with more crystallized and systematized delusions, as well as supporting perceptual disturbances in psychosis. Other symptoms and manifestations are common to both: impaired sleep, periods of low motivation and interest (avolition), social isolation, and ultimately, significant disability. Overvalued beliefs may also be confused with obsessions (and/or delusions), and distinguishing between all three is also critical for the forensic consultant[13].

While there are some distinguishing aspects in individuals with severe OCD or psychosis, there is also growing

research that suggests there may be a distinct subtype of OCD with schizophrenic features. In trying to establish a diagnosis in a patient with either OCD or psychosis, distinguishing between obsessions and delusions may prove challenging, leading some to argue that they lie on a continuum [14]. Obsessions have commonly been thought of as ego-dystonic, because they cause significant distress for the individual, who understands the obsessions as separate from their own wishes. Delusional thinking, however, requires that the individual have an investment in the reality of the thought regardless of whether it is distressing or not. While this distinction is helpful in many instances, in some cases of OCD, obsessions may be granted the same primacy as individuals with schizophrenia give delusions.

Following Meloy's [9] case study mentioned above, patient L who had originally been diagnosed with major depressive disorder and OCD, after stating that he wanted to kill his young children, so they could take their "innocence to heaven." His diagnosis was later changed to schizoaffective disorder, but it was noted that his homicidal thinking coincided with the onset of his OCD. L ended up killing his youngest son and claiming that the act made him "free of all the pressures of life," demonstrating that his homicidal thoughts were not ego-dystonic, as most characterizes OCD thoughts. In cases like L's, a diagnosis of both schizophrenia and OCD may point to a particular manifestation of OCD that combines features of schizophrenia and OCD, termed schizoobsessive or, alternatively, the schizotypy subtype of OCD[14,15]). Evidence of a schizotypy subtype of OCD comes from neuroimaging and neuropsychological studies, which have found that patients with both schizophrenia and OCD tend to have similar atypical brain patterns. Further, patients with OCD with schizotypal traits tend to have poorer insight into their condition, earlier age of onset, and greater learning deficits than those with only OCD (Sobin et al., 2000). A distinct diagnosis of a schizotypal type of OCD would perhaps facilitate the identification of a group of individuals diagnosed with OCD who are most susceptible to obeying their obsessive thoughts.

NEUROBIOLOGICAL AND NEUROPSYCHOLOGICAL UNDERPINNINGS

Historically, OCD was conceptualized under psychodynamic parameters, but has more recently become a model neuropsychiatric disorder with key electrophysiological findings, changes in brain structural morphology, glucose metabolism, neuropharmacological responses, and neuroendocrinological findings [16]. Researchers have attempted to identify neurocognitive endophenotypes that represent intermediate markers of brain dysfunction and act as vulnerability markers for disease development. Previous studies of neuropsychological deficits in patients with OCD indicate that impaired delayed verbal recall, set-shifting ability, visuoconstructive abilities, and dysfunction of inhibitory control are considered potential trait markers in patients with OCD. These trait markers indicate cognitive inflexibility and are linked to structural brain differences reported in unaffected first-degree relatives of patients with OCD[17].

Moreover, there are clear anatomical and physiological differences within the brain for individuals with OCD. Anatomical differences include abnormalities within the corticosubcortico areas [18]; reduced grey matter in orbitofrontal regions, and increased grey matter in the cingulate, parietal, and striatal regions[19]. White matter abnormalities were also observed within interconnecting neurons in individuals with OCD compared to those without OCD[20]. Additionally, Menzies et al.[Error! Bookmark not defined.], noted dysfunction within key brain regions associated with OCD such as the hippocampus, mediodorsal thalamus, substantia nigra, and amygdala. Physiological differences center around an increase in neurotransmitter dopamine and a decrease in serotonin for those with OCD [21]. Such neurotransmitters help regulate the activation of the aforementioned areas. Behavioral outcomes of such activation often include emotional regulation, habit formation, pleasure, and stress reduction. In combination, the under activation of frontal lobe circuitry with the increased production of dopamine and serotonin likely account for the cognitive inflexibility and motor impulsivity found in OCD[22].

Although OCD is not categorized as a neurocognitive disorder in the DSM-5TR, there are clear cognitive impacts of the disorder. Previous studies of neuropsychological deficits in patients with OCD revealed impaired delayed verbal recall, set-shifting ability, visuoconstructive abilities, and dysfunction of inhibitory control. As a group, these neuropsychological observations are considered potential trait markers in patients in OCD, as they indicate cognitive inflexibility and were linked to structural brain differences reported in unaffected first-degree relatives of patients with OCD[23]. Additional research has found impairments in delayed memory alternation learning, global attention, psychomotor speed, and visuospatial awareness[24,25]. Furthermore, Puialto and Segalas (2022)[26], conducted a neuropsychological evaluation on 44 outpatient clients with OCD with a follow-up neuropsychological evaluation after ten years. Results indicated that even as obsessive and affective symptoms improved, there was no significant change in the neuropsychological pattern found in patients with OCD, which further supported the potential for neuropsychological trait markers for OCD.

In identifying neurocognitive endophenotypes, the diagnostic sub-classification of patients can be refined based on the extent of their expression of endophenotypic markers. Future studies will seek to correlate the results of imaging and neurocognitive endophenotypes to identify regions outside the orbitofrontal loop that may be involved in OCD, as well as examine their links with genetic polymorphism. More recently, the protein SPRED2 was identified, and its specific absence was associated with the onset of OCD behaviors, providing a new neurobiological disease model that can lead to targeted treatments.

TREATMENT IMPLICATIONS

Effective treatment of OCD requires a multi-dimensional approach. Current treatment protocols include interventions ranging from psychotherapy, such as cognitive behavioral therapy exposure-response prevention (CBT-ERP), to pharmacological considerations monitored with plasma levels, to interventional procedures (such as deep transcranial magnetic stimulation, dTMS), and neurosurgery (deep brain stimulation and ablation). The use of electrophysiology for individualized treatment and predictors of outcome has also been proposed[27]. Several algorithms have been published to illustrate management[28,29].

Discussion

OBSESSIVE-COMPULSIVE DISORDER IN CIVIL SETTINGS AND FORENSIC EVALUATIONS:

Mental health diagnoses rank amongst the top five most costly medical expenses for American individuals, resulting in a significant and perhaps not fully quantified economic and labor impact. According to a report published by the National Institute of Mental Health (NIMH)[30], because of psychiatric illnesses, the economy bears a net loss of 190 billion dollars in earnings per year. With over 2.2 million Americans living with OCD, half of whom have been classified as severely debilitated, this diagnosis affects the professional lives of a large portion of the American population. OCD was classified as a disability under the American with Disabilities Act (ADA [31]) in 1997, when psychiatric disabilities were incorporated. In 2008, the Americans with Disabilities Amendments Act (ADAAA) expanded eligibility for accommodations, reducing barriers to ADA protection even if illness impact was mitigated by treatment[32].

In considering reasonable accommodations and disability discrimination, one must consider whether their OCD limits the employee's ability to perform the essential functions of the position, and if so, whether reasonable accommodations would enable them to perform those affected essential functions. In the case of *Earl v. Mervyns, Inc.* (11th Cir. 2000), the plaintiff claimed that his OCD prevented him from arriving to work on time in the morning. The court agreed with the employer that punctuality was an essential function of his position (as a retail manager) and concluded that no accommodation would meet the needs required given his OCD condition. Thus, the court deemed the plaintiff "not qualified" under the ADA and upheld the dismissal of his disability discrimination claim. In contrast, in *Humphrey v. Memorial Hosps. Ass'n* (9th Cir. 2001), the plaintiff was a medical transcriber with OCD, and the court concluded that the employer failed to consider whether either a leave of absence or telecommuting arrangement would have enabled the plaintiff to perform the essential duties of her assignment. Examples of OCD impacting the workplace and associated functions are also found at the supervisory level, where it might impact employees under their chain of command [33] or potentially make the workplace a hostile work environment.

Disability assessments should be tailored to the overarching entity guiding the parameters of functionality, whether that be a clinical guidance of functional disability, such as the Group for the Advancement of Psychiatry (GAP)'s Functional Assessment of Disability,[34] private disability insurance, or the Social Security Administration (SSA). Of note, the SSA's nine categories of listed impairments includes anxiety and obsessive-compulsive disorders in a single category [35]. An important distinction when assessing disability in an individual with OCD is to differentiate it from Obsessive-Compulsive Personality Disorder (OCPD), which may not qualify. The SSA does allow for disability under personality and impulse control disorders, alluding to "preoccupation with perfectionism and orderliness" (and others) in addition to the extreme or marked limitations in one or two of the four areas of mental functioning, but the disorder must be quite severe to preclude any kind of gainful employment.

For the forensic evaluator who is assessing disability, it is important to consider how OCD-related impairments may affect a person's ability to sustain gainful employment due to impairments in areas of cognition, social relationships, self-care or self-direction, work tolerance, or skilled performance. Specifically, OCD-related impairments may result in an inability to: adequately care for themselves in a manner that is adequate for the workplace (e.g., making it impossible to arrive on time); sustain required attention, concentration, persistence, and pace (e.g. due to interruptions for ritualistic behaviors); and maintain professional relationships with colleagues, supervisors, colleagues, and clients. These impairments may be exacerbated during times of acute decompensation. Furthermore, a person with OCD may find themselves unable to complete work consistently carrying out tasks with precision and without an unacceptable degree of error, or without necessitating excessive reassurance and confirmation of adequate performance. OCD patients may be unable to adapt to the shifting stressors of the work environment with flexibility, given the rigidity of certain rituals.

Given its prevalence and impact on functionality and executive functioning capacities, OCD should also be considered in forensic evaluations, such as disability associated with fitness for duty evaluations, parental fitness, and decisional capacities such as testamentary capacity, and medical decision-making.

Obsessive Compulsive Disorder in the Criminal Setting

Criminal responsibility, risk assessments, and mitigation efforts are three areas that OCD may present in the criminal setting. Special considerations must be given when assessing individuals with OCD for these purposes.

CRIMINAL RESPONSIBILITY

The insanity defense is a legal doctrine that, in certain conditions, absolves individuals with mental illness of criminal responsibility for their actions. Internationally,

there is no single universally adopted standard for criminal insanity.

The first legal test for criminal insanity originated in 1843 in England during the case against Daniel M'Naghten. M'Naghten claimed insanity after killing the secretary to the Prime Minister, Edward Drummond, believing he was the Prime Minister. After public outrage following M'Naghten's verdict, a stricter test for criminal insanity was created, often known as the "right-wrong test" or the "cognitive test" for its emphasis on knowledge of wrongfulness.

Presently, 46 of 50 states in the United States have adopted a variation of the M'Naughten test. Many countries, including the United Kingdom, India, and Australia have also adopted variations of the M'Naughten test. The Federal Insanity Defense Reform Act of 1984 represents a strict M'Naughten standard with the requirement of a severe mental disease or defect at the time of the act. Under the new federal insanity defense test, a defendant is not responsible for criminal conduct if, "as a result of a severe mental disease or defect, [he] was unable to appreciate the nature and quality or the criminality or wrongfulness of his acts.[36].

A criminal defense attorney may raise the issue of insanity when there are indications that mental illness impaired one's ability to distinguish between right and wrong, leading to the commission of a criminal act. It is worth considering OCD's place in an insanity defense standard because OCD is a condition in which the interplay between thoughts and behaviors is at its core. Although the prevalence of OCD and its comorbidity with psychotic disorders –which are the most common mental illness associated with a successful insanity plea – remains high, it is infrequently cited in the literature as a means for an insanity plea. One international case that does illustrate a complete acquittal of criminal responsibility for defendants with OCD as the primary diagnosis is from a High Court in India in 2013. This Court (which relied on Section 84 of the Indian Penal Code, an NGRI standard like the McNaughton standard) acquitted a juvenile with OCD after he murdered his mother[37] .

In general, individuals with OCD engage in compulsions to reduce or eliminate the overwhelming anxiety that they experience related to particular unwanted thoughts. Forensic psychiatrists may be asked to opine on cases in which an obsessional act may elicit a compulsion that violates the law. One such example may include patients with pedophilia OCD (P-OCD), a type of OCD in which individuals have intrusive thoughts of being attracted to children and repetitive compulsions to extinguish those fears. Patients with P-OCD are not attracted to children. Instead, they have a debilitating *fear* that they might be or a *fear* that if they are, they will be unable to resist an impulse to act[38]. On occasion, some P-OCD patients may seek out pornographic content to demonstrate that they were not aroused by it, whether with the simple and more immediate goal of eliminating the anxiety associated with the thought or with the broader and more self-probing goal of proving to themselves that they do not have sexual attraction towards children.

To neutralize intrusive, sexually-based thoughts, patients with P-OCD may engage in compulsive behaviors that result in legal ramifications for their behavior, such as a conviction, loss of child custody, or mandatory sex offender registration. For these reasons, a forensic evaluator should not only ask about and document the nature of the compulsive acts but specifically assess any connection between the alleged criminal behavior and the mitigation of anxiety caused by an associated intrusive thought. Malingering should be given strong consideration during a forensic evaluation, given that the compulsive act may have led to criminal conduct.

CONSIDERATIONS IN THE DETECTION OF MALINGERING OCD SYMPTOMS:

Although there is no definitive way to determine whether a defendant is malingering symptoms of OCD, specific patterns of behavior may provide the evaluator with clues that suggest a higher probability of malingering. First, individuals with genuine OCD will report an initial decrease in anxiety after engaging in a compulsion, followed by a period of escalated distress and doubt about the intrusive thought, leading to justification for subsequent compulsive acts. Given that OCD is, by nature, a disease of repetitive thoughts and behaviors, evaluators should be cautious about assigning a diagnosis of OCD for a compulsion that is reportedly completed only once. Second, evaluators should assess for inconsistencies between reported and presenting symptoms. Individuals who claim to be "cured" or "suddenly well" without any therapeutic interventions for the behavior that resulted in the alleged criminal act should raise doubt about the authenticity of OCD symptoms. Lastly, one should have a high level of suspicion for malingering if compulsions are described as involuntary motor acts. Compulsions are repetitive behaviors that a person with OCD feels the urge to do in response to an obsessive thought rather than spontaneous or purposeless movements.

Evaluators should pay special attention to any exaggerated efforts to attribute one's behavior solely to mental health symptoms and to any "dramatizing" of symptoms. Individuals with OCD typically experience shame and embarrassment related to their intrusive thoughts and often engage in self-stigmatization. In cases involving P-OCD specifically, a distinguishing feature may be the presence of compulsive behaviors while watching pornographic content such as bodychecking, whereas a malingerer would be unaware and likely masturbate either during or after watching. Finally, as with other forensic evaluations, it is best practice to seek contemporaneous data from external sources (e.g., medical or mental health records, reports from family/friends, employment records) that corroborate levels of distress caused by intrusive thoughts independent of the alleged criminal act.

Special considerations: volition and insight in OCD[12]

A successful insanity defense hinges on proving a cognitive component to understanding wrongfulness. The complex interplay between voluntary control, insight, and cognition in OCD adds an additional layer when assessing criminal responsibility. Forensic evaluators have a unique opportunity to uncover these nuances in their assessments and can assist courts by clarifying the diverse clinical presentations of OCD.

Important considerations with OCD in the criminal setting include questions regarding the volitional nature of compulsion and the level of insight preserved by the individual with OCD. Although few studies have investigated how frequently individuals with OCD act on their obsessions, there are emerging clinical models of OCD that are relevant to forensic psychiatrists, who may apply this understanding when assessing defendants for mitigation or criminal responsibility. Rotter & Goodman[39] examined the relationship between insight and volitional control in patients with OCD. The study measured patients' subjective sense of decreased control over their compulsions. Utilizing the YBOCS, the authors found that in OCD patients, levels of insight into irrationality of a patient's behavior were not significantly related to the experience of volitional control. However, insight positively correlated with control over obsessions [39]. Another study, by Grassi, et.al, (2015) found that OCD patients were more impulsive than controls, demonstrated increased risky decision-making, and showed more biased probabilistic reasoning. Based on these results, the authors suggest that OCD may be conceptualized as a type of "behavioral addiction" with reward-system dysfunction [40]. All in all, acting on violent obsessions remains quite uncommon[41].

Although some individuals with OCD preserve insight into their obsessions or compulsions as being irrational, this is not always true in cases with severe pathology. [42] Even if insight remains intact, its correlation with the ability to control compulsions must be considered. In the previously mentioned study by Rotter and Goodman (1993) [39], no relation between insight and resistance to compulsion (i.e., actions that help avoid triggers) was discovered. Insight was, however, correlated to control over obsessions, suggesting that although insight helped control thoughts, it had no effect on propensity of carrying out their compulsions. It is also important to recognize that compulsive behaviors may arise as attempts to neutralize intrusive thoughts that are both ego-dystonic and also criminal or dangerous in nature (e.g. setting a fire to alleviate intrusive thoughts of hurting another passenger in a bus). Therefore, it is critical to explore the egodystonicity of the thought, and the engagement in other types of alleviating behaviors, such as avoidance, rather than compliance with the compulsion.

Risk Assessments

Assessment of the least restrictive alternative for patients experiencing OCD who present with either obsessions or compulsions of high risk, violent or dangerous content is critical. For a post adjudication patient in a forensic hospital setting, assessment of risk associated with any remaining symptoms (of OCD and/or other psychopathology such as schizophrenia) may be the defining factor in making a recommendation for community release. Conversely, in an outpatient setting, a patient presenting with offensive obsessions may not automatically require hospitalization, especially given the chronic nature of the illness. Hence, we examine a few situations in which thoughtful and methodical risk assessment of dangerousness is warranted to determine the risk of dangerous behaviors actually being enacted.

COMMUNITY RELEASE

The underdiagnosis of OCD has serious consequences in the forensic treatment setting. Of relevance is conducting risk assessments for community release of post-trial patients, who often present with comorbid, severe, and sometimes treatment-resistant pathology (e.g.,psychosis and/or substance use disorders). In this context, OCD may impact length of stay in a more restrictive treatment setting, such as the forensic hospital. Perhaps more importantly, the risk of self-harm or suicide may increase, with failure to capture in recurrent suicide risk assessments. In fact, the use of conventional risk assessment tools may yield equivocal results when applied to patients with severe schizo-obsessive psychopathology. Suicide is a significant risk for patients with OCD.

Tracking compulsive behaviors, even those that are non-offensive or non-dangerous in nature, may be useful indicators of increasing intensity of obsessions. A patient may engage in safety-assuring compensatory compulsions to counter harm-themed obsessions. Increased compulsions, an objective and measurable behavioral sign, may signal increased harm-inflicting obsessions, which could inform risk assessment, especially with associated limited impulse control. If so, an awareness of an increase in compulsive behavior could be used as a warning sign for forthcoming offensive compulsive behavior and can therefore become a therapeutic target for intervention.

Alternatively, increased (non-offensive) compulsions as a mechanism to avoid engaging in the troubling harm-inflicting obsessions could reduce the urge to follow through with an offensive compulsive behavior derived from the harm-inflicting obsession. So long as the tension reducing compulsion is non-harming, increased presence could represent a measurable protective factor for recidivism or violent risk assessments. As it relates to treatment, behavioral therapy could then target the non-offensive compulsions to either replace them with adaptive behavior or reduce the overall frequency (with monitoring to ensure the harm-inflicting obsessions do not reemerge).

SPECIAL CIRCUMSTANCES OF POTENTIAL HEIGHTENED RISK OF VIOLENT BEHAVIOR

Some special populations, such as postpartum patients and those with paraphilias, deserve special considerations when assessing risk. The postpartum period is associated with an increased risk of developing OCD[43]. It is often undiagnosed and untreated[44]. Patients with postpartum psychosis may have a risk of actually harming the infant, since they may not develop avoidance behaviors that are common to patients with OCD. Patients with postpartum OCD engage in safety behaviors to decrease the likelihood that their intrusive, harm-based thoughts will lead to destructive behaviors (e.g., avoid bathing the baby or avoid being around knives). OCD has received less attention when compared to cases of postpartum depression, though 87% of women presenting to a perinatal mood disorders clinic had intrusive, obsessive-like thoughts, with half of those women experiencing clinically significant obsessions[45].

A less common but severe form of OCD, Post-partum infanticidal OCD, can present as an abrupt adult-onset OCD, contrary to the classical age of onset and progression. The symptoms of postpartum onset OCD may consist of obsessional intrusive thoughts about harming the newborn without compulsions or with both obsessions and compulsions. Compulsions in this context may include reassurance (e.g. repeatedly checking the well-being of the child), and avoidance behaviors (e.g. not bathing the baby, avoiding knives, refusing to let themselves be left alone with the child). Women with OCD without psychosis or a severe personality disorder do not have an elevated risk of aggressive harm to their infants.

An exploration of all psychopathologies with a ruminative (colloquially conceptualized as "obsessive-compulsive") component is beyond the scope of this paper and should certainly be an area of further study. However, it is a common consideration in certain patients with sexual deviance, in which they often describe recurrent intrusive and egodystonic thoughts that guide behavior, making it difficult to distinguish from the egosyntonicity of paraphilias on one end, but OCD on the other. A study conducted on 42 pedophilic sex offenders demonstrated that 93% of their sample also met criteria for a comorbid mental illness diagnosis. The most common conditions included obsessive compulsive, antisocial, avoidant, narcissistic, and paranoid personality disorder. Another source documented that 60% of their paraphilic sex offender population exhibited symptoms of a comorbid mental illness, of which one of the more prevalent diagnoses was obsessive compulsive disorder.[46]

Beyond considerations of population or categories of diagnoses, some specific behaviors of concern may be associated with O-C features. The symptoms of OCD are not confined to excessive re-enactment of socially acceptable behaviors but can expand to thoughts found repugnant by the patient, morally unscrupulous obsessions, or compulsions involving unlawful behaviors. Patients can have obsessions of sexual, destructive, and blasphemous nature that are in violation of morality and values. Common examples include thoughts of harming innocent individuals, forcefully touching someone sexually, having intercourse with religious prophets, or committing sins. Another form of repugnant obsessions exists in the form of doubt, where patients are in constant worry that they have committed an abhorrent act, such as poisoning someone, sexually assaulting a child, or wondering if they are homosexual. Such obsessions lead to compulsions of reassurance, leading patients to perform ritualistic behaviors to ensure their doubts have not occurred (or will not in the future), and may even lead to asking law enforcement for confirmation of their innocence. In these instances, patients may seek to engage in a behavior that reassures the obsession is not true. For example, a patient who has intrusive thoughts of sexually assaulting a coworker may constantly monitor the coworker's well-being for reassurance, perhaps leading to stalking-like behaviors. Obsessional stalking is relevant in multiple assessments, including threat assessments as well as fitness for duty evaluations. Furthermore, as described by Meloy (2005) [47], obsessional cognitions suggest a psychobiological preoccupation that enables the stalker to ignore social and legal constraints. Comorbidity of OCD may be particularly relevant in forensic child evaluations, which deserve a dedicated exploration.

Mitigation of Penalty

Although OCD is less frequently used as a successful defense to exculpate insanity, it may be raised during the sentencing phase as a consideration for mitigation to reduce blameworthiness. Forensic evaluators, who may be asked to opine about mitigating factors for defendants with OCD at the sentencing phase of a criminal case, should be familiar with not only the relevant diagnostic criteria but also how an individual's intrusive thoughts and compulsions relate to the conduct constituting the offense. Obtaining a detailed account of any ritualizing behaviors, actions the individual engaged in to alleviate the distress caused by obsessional thinking, and perceived consequences of refraining from engaging in such behaviors can be helpful to courts. Evaluators should also assess the degree to which insight about one's OCD symptoms is preserved, as this could have important implications for the likelihood of future treatment compliance. Recommendations for future treatment are frequently permitted in mitigation reports and, based on the symptom severity and level of insight maintained by the client, can be included to guide the court during the sentencing process.

Given the high comorbidity between OCD and other mental disorders, highlighting these co-occurring conditions can underscore the overall impact they can have and can add credibility to a mitigation assessment. In *R v Marson-Wood* [48], for example, a forensic psychiatrist testified in a New Zealand High Court during the mitigation phase for Mr. Marson-Wood, who lit 31 fires in the community. Although the Court did not specify the nature of Mr. Marson-Wood's specific OCD

symptoms, it reduced his custodial sentence in consideration of his multiple psychiatric comorbidities, including OCD, ADHD, ASD, anxiety, and depression.

Undoubtedly, there are other important areas in which OCD surfaces in the criminal setting, such as in competency to stand trial evaluations, which are beyond the scope of this paper. Furthermore, the pathology (whether primary or comorbid) carries diagnostic relevance particularly for appropriate treatment in the pursuit of prompt competency restoration and sustained stabilization.

Conclusion:

While research on the etiology and symptomology of obsessive-compulsive disorder (OCD) is plentiful, there remains a paucity of discussion on the disorder's relevance to forensic settings. The high comorbidity rates of OCD with other psychiatric conditions such as psychotic disorders and anxiety, coupled with the underdiagnosing of OCD, exposes a need for further analysis and a richer discussion. Areas of consideration should include forensically relevant subcategories of OCD (i.e. religious scrupulosity, confessional, and existential), neuropsychological sequelae that may account for criminal behavior (e.g., impulse management and cognitive inflexibility), and anatomical and physiological abnormalities (e.g., level of brain activation, serotonin, and dopamine levels). Such recognition could create a richer context for why and in what conditions an individual with OCD may find themselves within a forensic-based situation.

Clinical conversation should focus on keen differential diagnosis that emphasizes subtypes of OCD that are prolific within forensic settings such as religious scrupulosity, confessional, and existential. Such differences could help delineate appropriate diagnoses from comorbid conditions and help to avoid misdiagnosis. Furthermore, clinical considerations should extend into the neurological and neuropsychological correlates to OCD. Examples of consistent neuropsychological impairments include cognitive inflexibility, disinhibition, and disrupted set-shifting. Recognizing the various neurobiological and neuropsychological markers could support more effective behavioralty differentiation across subtypes of OCD. Together, better classification could lead to more effective and targeted psychotherapeutic and psychiatric interventions. Lastly, understanding the unique psychiatric and neuropsychological patterns found in OCD inform forensic assessments in multiple domains.

A strong understanding of OCD exposes discussion points on the impact OCD could have on civil and criminal proceedings. In civil contexts, providers must review the social cost of mental health and the balance with accommodations to support an individual within a work environment. For example, review of the ADA and specific work requirements in the context of OCD symptoms is essential for disability assessments. While other considerations include the clinical impacts of OCD on parental capacity, testimonial ability, and effective decision making. Specific to criminal context, prior court cases have outlined the requirements for an insanity defense, which opens conversation for the overlap with clinical features of OCD. Still, individuals may find themselves engaging in criminal behavior in efforts to assuage the anxious distress caused by OCD. Within this context, risk-assessment becomes important and the ability to apply an understanding for OCD across a variety of criminal behavior becomes critical. The impact of OCD symptoms on understanding of insight, volition, wrongfulness, voluntary confessions, and reality testing are of particular interest in forensics settings. Combined, knowledge for the effects of OCD within criminal settings could guide mitigation. Naturally, situations with significant consequence comes the concern for malingering. Understanding atypical patterns of symptom reporting including: single episodes, significant inconsistency across symptoms, dramatization of symptoms, discrepancy within symptom expression, and claims to be "cured" or "suddenly well" without therapeutic intervention could strengthen an opinion of malingering.

Future research may continue to understand biological and neuropsychological correlates to OCD, stronger categorization of symptomology could lead to better diagnostic criteria, and both could lead to more effective treatment. Within the forensic context, future research could continue to identify the frequency of appropriate OCD diagnoses and the use of an appropriate understanding for OCD to a civil or criminal case.

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