Royal Australian & New Zealand College of Psychiatrists

Scholarly Project

An examination of the phenomenology of delusions, overvalued ideas and obsessions

Word count: 3942

Excluding table of contents and references

Table of Contents

Abstract

Delusions, overvalued ideas and obsessions can be difficult to differentiate in clinical practice, and this has important implications for diagnosis and treatment. Evaluation of various conceptualisations of these terms can potentially identify core differences. This narrative literature review aims to define and delineate phenomenological differences between these terms. Key features that are not routinely included in current definitions are identified, such as the irreducibility of delusions, the significance of personality, context and emotion in overvalued ideas, and resistance and capacity for control in obsessions. The benefits and drawbacks of conceptualising these terms as continuous or categorical are examined. The concept of insight and the usefulness of a dimensional approach to understanding phenomenology are reviewed.

Objective

To define and delineate the phenomenological differences between delusions, overvalued ideas (OVI) and obsessions.

Background

In clinical practice, it is often difficult to distinguish delusions, OVI and obsessions. Although diagnostic criteria, such as the Diagnostic and Statistical Manual (DSM) define these terms, distinctions are vague and often arbitrary.[1-3] Indeed, the criteria for obsessive-compulsive and related disorders (OCRD) have been revised in DSM-5 to include a delusional specifier, suggesting the relatedness of delusions and obsessions.[4] Conceptual confusion can lead to misdiagnosis, which has significant implications for treatment and eventual outcomes.[5,6] Furthermore, there may be

geographical variability in defining these terms, with it being argued that the European concept of OVI is broader than its North American counterpart.[7] The result is ambiguity, when what is required is specificity of language to ensure consistent practice. Unclear definitions may lead to phenomenology being moulded to fit an already developed clinical impression, rather than acting to inform it.[8] In other areas of medicine, pathology can be communicated in unequivocal numerical terms such as a blood pressure or a white cell count. Conversely, psychiatry relies heavily, if not entirely, on the qualitative description of experience. As such, the reliability and validity of phenomenological terms are paramount.

Although psychiatry is shifting towards a 'bottom-up' translational approach to diagnosis, the status quo of a phenomenology-driven system is likely to remain in place for the foreseeable future. Phenomenology may not have the prominence it once had in the teaching of psychiatry, as an increasing focus is being placed on the biological understanding of disorders. Despite these scientific advancements, the clinical practice of psychiatry necessitates unambiguous definition of phenomenological terms. This area of psychopathology should therefore be prioritised in psychiatric education to maintain a standard of practice.

There is a paucity of recent literature regarding this topic of psychopathology with limited empirical evidence. There are few comparisons of all three terms, with some exceptions considering the occurrence of these phenomena in individual disorders, such as obsessive-compulsive disorder (OCD) and pathological jealousy.[9-11] Despite the relative lack of investigation, this area of phenomenology remains pertinent. Furthermore, ongoing debate exists regarding the dimensional nature of psychiatric disorders, which relates to the consideration as to whether phenomena, such as those being presently considered, exist on a continuum or are categorically distinct.

Hypothesis

It is hypothesised that there are key phenomenological differences that may assist in discriminating and differentiating these phenomena, beyond the conventional descriptors in use today. Examination of perspectives spanning from original descriptions to present day definitions may identify complexities and nuance that do not feature in current conceptualisations.

Methods

A narrative literature review addressing the aforementioned objective was undertaken. This review type was selected to allow for synthesis of a range of perspectives from varying literature sources. Ethics approval was not required due to the low risk nature of this study. A search of online databases using the Ovid platform was undertaken (PubMed, PsycINFO, MEDLINE, EMBASE and PREMEDLINE). The following search terms were included *delusion, overvalued idea, over-valued idea, obsession, phenomenology, conceptual, nomenclature, nosology, psychopathology, nosography.* Results were restricted to English language with date limits from earliest publication available to July 2017. A total of 306 results were reviewed by a single researcher. Titles and abstracts were assessed for relevance. Inclusion criteria required the phenomenology of delusions, OVI and/or obsessions to be a focus of the publication. Results that did not meet these criteria were excluded. Additional literature was included through searching of reference lists. A further four texts were added through a search of standard psychiatric textbooks. Thus ultimately, a total of 45 publications were included in this review.

Results

Delusions, OVI and obsessions are broadly considered pathologies of thought content. This relates to the concept of belief, which Yaryura-Tobias (2004) defined as the rational acceptance of a statement, event or episode.[11] A belief requires a judgement to be made by an individual attesting to the truth or existence of an object or concept. [9] Belief systems rely on validation, reason and perception.[11] However, the relationship of the phenomena being presently considered with underlying beliefs is not always clear. Obsessions are defined as thoughts, urges or images, and although they may be accompanied by beliefs, this is not a requirement.[4,9] For example, an obsession regarding symmetry may not have an associated underlying belief, whereas an obsession regarding contamination may be related to beliefs regarding hygiene. Whether delusions constitute belief has also been debated, with Berrios (1991) arguing delusions are “empty speech acts disguised as beliefs”.[12] By considering delusions as beliefs, there is a risk of overemphasising the nature and characteristics of the thought and suggesting that treatment should focus on belief modification.[13] Such an approach may be at the expense of understanding how a delusion relates to the psyche, and conceptions of the self and the world. However, delusions do share superficial similarities with beliefs, in that both involve the individual accepting and attesting to the truth or existence of an object or concept.[13]

Delusions

In *General Psychopathology* (first published in 1913), Karl Jaspers described the *delusion proper* and the *delusion-like idea*, and these concepts have gone on to form the basis for current definitions. The former was described as “psychologically irreducible”; a belief held with strong conviction, impervious to experience or counter-

argument, and characterised by impossible or bizarre content.[14] For the individual, this resulted in a new way of seeing the world, without contextual precedent.[8] Kurt Schneider subtyped delusions proper further into delusional mood, sudden (autochthonous or primary) delusional ideas or delusional perception.[15]

In contrast to the attribution of new meaning to a normal percept in delusional perception, a delusion-like idea was described as a belief originating understandably from false perception, derealisation whilst in an altered state of consciousness or a strong emotional experience.[14] A categorical distinction was made between delusions and normal beliefs, because Jaspers considered delusions proper and delusion-like ideas to be distinctly abnormal processes.[16] However, the distinction between delusion-like ideas and OVI was not made entirely clear, and OVI and normal beliefs were viewed as part of normal mental life.[8]

Overvalued Ideas

The OVI was first established as a concept within psychopathology by Carl Wernicke in 1900, but it has since been somewhat neglected.[7] Prototypical disorders include the querulous paranoid state, pathological jealousy, body dysmorphic disorder (BDD) and anorexia nervosa (AN).[16] Initially, an OVI was regarded as a dominant and solitary belief consistent with the individual's personality. Therefore, it was never considered to be senseless by the person, especially as the belief often took form following an emotionally arousing experience.[16] For example, a person who tends to be suspicious and perceive external attacks may take great offence to a slight injustice and begin to make complaints, before progressing to legal action. For years, the event becomes the sole focus of the person's thinking and energy. Considering the minor nature of the original event, the person's response is clearly

disproportionate. However, the belief of injustice, whilst exaggerated, is neither impossible nor bizarre, so does not appear to be delusional.

This example demonstrates how OVI are understandable in the context of an individual's personality and background, and how these beliefs may arise from key, life-changing events, unlike the distinctly alien nature of primary delusions.[17-20] Jaspers (1959) drew the distinction between OVI and normal belief as the abnormal way in which events take on meaning in OVI.[1] This description of OVI bears resemblance to the delusion-like idea, which in the original definition, could also arise from a strongly charged emotional experience. Although the relationship between these two phenomena was not clarified in early descriptions, they appear to be associated concepts.

Intense emotional experience is thus essential to the development of an OVI. This intensity may explain the determination with which these ideas are acted upon, unlike delusions, where there may be disparity between conviction and associated action.[9,11,17] Personality is also a key component in the definition of OVI and it greatly informs the understanding of the origins of the belief. Concordance between an OVI and premorbid personality style is essential. The preservation of personality in OVI, as opposed to the deterioration typically seen in schizophrenia, has been considered as characteristic.[21] However, interestingly, the importance of context, personality and associated emotion is not included in the DSM-5 definition of OVI and similarly it is not routinely given consideration in clinical practice. Instead, DSM-5 simply defines OVI as an unreasonable and sustained belief held with less than delusional intensity.[4]

Obsessions

The original descriptions of OCD in English, French and German psychiatry vary.[22-24] The English saw OCD as related to religion and melancholy, whereas the French linked the disorder to doubt and a function of the will.[24] Jean-Etienne Esquirol's description of an obsession in 1838, as a recurrent or persistent idea, thought, image, feeling or movement, accompanied by resistance and insight, has shaped the current definition substantially.[25] However, although Esquirol made reference to 'movement', the DSM-5 defines obsessions primarily as a mental or emotional experience – thoughts, urges or images.[4] More recently, there has been mounting evidence suggesting that so-called sensory phenomena, which are physical urges associated with compulsions, should be incorporated within this definition.[26] These urges may come in the form of physical sensations or drives to release energy through behaviours.[26]

Karl Westphal (1877) emphasised the intrusion of an ego-alien obsession on an intact intelligence, which is consistent with modern definitions.[11,23] Other relevant historical figures include Richard von Krafft-Ebbing (1867), who noted the importance of mood and linked obsessions to melancholia, even though others, such as Wilhelm Griesinger (1868) disagreed.[23] This facet does not feature within the current conceptualisation.

Resistance and the capacity for control are also considered to be essential features of obsessions, and it has been argued that if these are absent, then this specifies the point at which an obsession becomes a delusion.[1,24]

Unlike delusions, which can be diagnosed across a range of disorders, obsessions are typically reserved for OCRD. However, it has been argued that obsessions

should be considered a distinct dimension across psychiatric disorders and one that perhaps also extends into normal mental life.[11,27] This highlights the debate that underpins many psychiatric phenomena, that is, whether they are best captured categorically or as dimensional constructs.

Continuum versus categorical models

There is recurrent debate as to whether delusions, OVI and obsessions are categorical or continuous phenomena. The categorical distinction between delusions and non-delusional ideas likely has origins in Jaspers' original definition.[28] However, increasingly, normal beliefs, OVI and delusions are thought to exist on a continuum, and a model which defines obsessions, OVI and delusions as continuous phenomena has also been posited. [29-31]

One of the reasons for this paradigm change is the fluidity of thought and the ability for their nature to shift and transform. For example, it has been suggested that filtering of information may result in an obsession becoming an OVI.[32] Similarly, obsessions can evolve into delusions, for example doubting obsessions of accidentally poisoning a family member may transform into delusional guilt that one has caused an illness. However, this type of psychosis is usually well circumscribed and the delusional conviction is reversible.[11,33] It has even been suggested that a continuum extending from a preoccupation to hallucination be considered, with a preoccupation developing into an obsession, then a delusion and finally a hallucination, as the independence of thought is gradually projected outside the self.[34]

This approach leads one to question how far this spectrum extends and whether certain processes are distinctly different entities. Whilst the continuum model has

gained popularity, the debate is not yet resolved.[28] Although this model captures variability in clinical presentations not considered by a categorical classification, it does not negate the need for an cut-off point, because ultimately in practice it is necessary to separate illness from health.[6] Mullen (2003) concluded that either model could be justified, whereas others have found that although seemingly plausible, the concept of a continuum is not clearly supported.[1,28]

In continuous models, OVI in particular are often considered an intermediary, between obsession and delusion or between normal belief and delusion. It has been suggested that OVI may sometimes be an early sign of illness, later transforming into delusions or other symptoms.[20] However, the original conceptualisation of OVI indicated core features, such as the importance of personality style and the prominence of emotion, making it a distinct entity. Mullen and Linscott (2010) argue that the overlap between disorders with delusions and OVI is the exception rather than the rule, and that these are decidedly different phenomena, rather than related concepts existing on a single continuum of severity.[19]

By adopting a continuum model, there is a risk that OVI come to exist in a phenomenological grey area. The term may become ‘retrofitted’ to align with the psychopathology suspected by the clinician. This results in the phenomenology being informed by the diagnosis, rather than the converse. If OVI becomes synonymous with a transitional state between two phenomena the core meaning of the term is in danger of being forgotten or lost altogether.

Insight – the only dimension?

If a continuous model is adopted, the relevant dimensions must also be reviewed. The most prominent of these is insight, and in clinical practice as well as in current diagnostic systems, insight is used to signify severity.

Insight is typically considered to be the recognition that a belief may be untrue and attributable to an illness. In OCD, a wide range of insight exists across the disorder and a small subset of individuals have no insight.[26,35] Lack of insight is equated with delusional intensity in the DSM-5 specifier for OCRD.[4] However, the validity of this correlation is questionable. Insight that an obsession is attributable to an illness (OCD) can be situation bound and fluctuates depending on the perceived environmental threat, whereas insight, or lack thereof, is generally more stable in delusions.[1,2,36] Additionally, insight in OCD can be intellectual rather than emotional, for example an individual may be able to verbally demonstrate insight whilst adopting inconsistent behaviour.[36] Insight itself is multidimensional rather than unitary, and the DSM-5 subtyping does not adequately acknowledge this, as it only relates to the recognition that a belief is untrue.[4] In addition to acknowledgement of inaccuracy, insight may also relate to the attribution of a thought to an illness.[9,37] Simply referring to 'insight' may fail to recognise these variants.

Mullen and Linscott (2010) demonstrated in a small study of community patients that insight (of having an illness) is a poor differentiating feature when comparing delusions and OVI.[19] The authors noted that poor insight is often used interchangeably with excessive conviction, which relates to the strength with which a belief is held. Similarly, conviction is comparable in delusions and OVI. In contrast, features such as factors that modify belief, preoccupation, plausibility, origin, onset

and response to others' opinion were shown to be more relevant in distinguishing these two phenomena.[19]

Taking a multidimensional approach

In a continuous model, equating insight with severity and using this alone to make distinctions between terms implies that delusions, OVI and obsessions exist along a one dimensional spectrum, with insight determining where a belief exists. Using this model, it has been suggested that intensification of belief can transform the nature of one symptom into another, for example shifting an obsession into a delusion.[11] However, belief intensity itself is multifaceted and not merely based on degree of insight, and recognising additional dimensions may have more clinical utility.[29] This leads one to question what dimensions, in addition to insight, can be used to indicate the nature of belief. Strauss (1969) argued for a multidimensional continuum model, considering conviction, preoccupation, plausibility and cultural context.[28,38] Distress and associated action have also been suggested as dimensions that may determine belief intensity.[29]

Veale (2002) suggests that the prominence of insight as a diagnostic indicator may be particularly North American, especially as the European concept of OVI, based on original descriptions by Jaspers and Wernicke, is broader and involves additional dimensions such as preoccupation, predisposing personality, past experience, associated affect and degree of action.[7]

The form and content of beliefs are also relevant dimensions to consider when differentiating these phenomena. Burgy (2007) considered the content criterion of absurdity and incomprehensibility key to the diagnosis of obsession.[23] Although the form of obsessions has been likened to that of delusions, in that both are intrusive,

have a gradual onset and have a quality of impermanence, it is likely that it is this form, rather than the thought content itself, that differentiates these phenomenological processes.[11] Early phenomenologists, such as Jaspers, recognised that form rather than content was of greater relevance.[8] Others have identified that the abnormality in delusion arises not from the qualities of the thought itself but from the breakdown in the evaluation of new information, or in other words, the form in which the thought develops.[3,39,40]

An additional dimension to consider is that of conviction, which is considered central to the concept of delusion. However, throughout the literature it has been highlighted that conviction is not always complete in delusions and non-delusional beliefs can also be held with unshakeable conviction.[13,28,38,41] An example of this is a superstitious belief held with certainty that a pair of lucky socks helped one to pass an exam, where there is an absence of a rational link between observation and derived belief.[3] Conviction is thus an inadequate basis with which to differentiate delusions and OVI, and overemphasising this can lead to OVI being misdiagnosed as delusions.[13,19]

Rather than strength of belief, perhaps the associated value is of greater importance. Veale (2002) described the 'idealised value' that underlies belief, such as the value of self control related to the belief "I am getting fat" in AN, and suggests that identification with and rigidity of the value are better indicators of severity.[7] Walker (1991) similarly dismisses conviction as an essential diagnostic criterion, and refers back to Jaspers in arguing it is the origin, or the irreducibility, of the thought that defines the nature of a pathological belief.[8]

Several attempts have been made to develop assessment tools to evaluate various dimensions of belief, which may subsequently aid in definitions. Brakoulias (2011) assessed conviction, fixity, fluctuation, resistance, insight regarding inaccuracy of belief and insight regarding attribution of belief to illness in OCD related beliefs.[9] This has since been generalised more broadly.[42] In addition to these dimensions, the Overvalued Ideas Scale (OVIS), which has been applied in OCD, examines bizarreness, belief accuracy, reasonableness, effectiveness of compulsions, pervasiveness of belief in society and the reasons others do not share the belief.[32] The Brown Assessment of Beliefs Scale (BABS) evaluates the delusionality of belief, and considers conviction, perception of others' views of belief, explanation of differing views, fixity, attempts to disprove belief, insight that the belief is due to an illness and co-occurrence of ideas or delusions of reference.[43] Clearly, the list of dimensions evaluated is long, and there has been little consideration of the weighting and importance given to each aspect.

Another approach is to view the differences between delusional and non-delusional beliefs as qualitative rather than quantitative. Rather than assessing belief intensity or strength of conviction, considering the belief in the context of an individual's view of themselves and the world may reveal more important differences.[13] Burgy (2007) highlights the importance of reflexivity, the capacity of an individual to reflect on the contents of their own consciousness, and argues that this is essential in defining obsessions.[23] The relationship between the belief and the self is further explored by De Haan (2013), who suggests OCD results from an inability to tolerate parts of the self that oppose one's general self concept.[44] However, the difficulty of this qualitative approach is that it depends heavily on self-report and memory, which introduces the potential for confounding and bias.[18]

These constructs are complex, and universally accepted conceptualisations are yet to emerge. Variance of clinical presentations within diagnostic categories is common. Divisions such as that between neurosis and psychosis have been incorporated into diagnostic criteria, when in fact, these disorders may not be mutually exclusive.[2,24,33] For example, there are important similarities between obsessions and delusions, such as the loss of control of thought, the domination of the thought and the gradual transition from normality.[24] Certain disorders may have both obsessional and delusional variants, such as pathological jealousy and body dysmorphic disorder (BDD).[10,45] The DSM-5 specifiers recognise this for OCRD, however this has not been extended to other diagnostic categories. For example, whilst the cognitions of AN have most often been compared with obsessions, it has also been argued that delusional variants exist.[35] Further understanding of this may have significant implications for treatment. The development of a nosology which permits overlap of diagnostic classes and adopts a dimensional understanding may allow for more precise conceptualisations of disorders.[35]

Discussion

This narrative literature review addresses the stated objective to define and delineate phenomenological differences between delusions, OVI and obsessions, through a synthesis and critique of available evidence. The complexity of the constructs being studied and the need to evaluate the development of concepts over time necessitates the use of a narrative review. However beyond identifying key issues, this style of review is unable to provide firm conclusions. It is also limited by the paucity of high level evidence and available literature. The potential for subjectivity in study selection with this methodology introduces possible bias.

However, this review does highlight potential constructs for conceptualisation of these phenomena. Specifically, it provides insight into the deficiencies of current definitions, and points to further areas for research. This could contribute to future definitions of phenomenological terms, which has the potential to improve accuracy of diagnosis, and subsequently treatment, of mental disorders.

Conclusion

There is variability in the conceptual understanding of phenomenological terms, and this is of concern, given the potential for misdiagnosis and inconsistent practice. Returning to the original descriptions reveals core features, which do not necessarily prevail in current definitions. These features include the irreducibility of delusions, the significance of personality, context and emotion in OVI, and resistance and capacity for control in obsessions.

Furthermore, debate persists as to whether certain phenomena are categorical or continuous. The benefit of the continuum model is that it recognises the ability for thoughts to transform over time. However, in this model, phenomena such as OVI become synonymous with transitional states, and core characteristics of the term are lost. This has the potential to detract from the precision of phenomenology being used in clinical practice.

Despite its drawbacks, the continuum model does allow for additional dimensions to be considered. Although insight is most commonly referenced, this is not a unitary concept and may not be an appropriate differentiating feature. Additional dimensions have been considered, particularly in the development of assessment tools; however, there has been little investigation regarding the relative importance of each of these dimensions. Further research in this area is recommended.

Diagnostic classes are not mutually exclusive, and throughout the literature it is apparent that there are variants of disorders. Further clarification of the precise nature of phenomenological terms may shed light on this variability and aid in the development of future diagnostic systems and treatments.

References

1. Kozak MJ, Foa EB. Obsessions, Overvalued Ideas, and Delusions in Obsessive-Compulsive Disorder. Behav Res Ther. 1994; 32(3): 343-353.
2. Simpson HB, Fallon BA. Obsessive-Compulsive Disorder: An Overview. Jour Psychiatr Pract. 2000 Jan; 6:3-17.
3. Jones E. The Phenomenology of Abnormal Belief: A Philosophical and Psychiatric Enquiry. Philos Psychiatr Psychol. 1999 Mar; 6(1): 1-16.
4. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th Edition. Washington DC, United States of America: American Psychiatric Association Publishing; 2013.
5. Leung JG, Palmer BA. Psychosis or Obsessions? Clozapine Associated with Worsening Obsessive-Compulsive Symptoms. Case Rep Psychiatry. 2016: 1-5.
6. Radden J. Belief as Delusional and Delusion as Belief. Philos Psychiatr Psychol. 2014 Mar; 21(1): 43-46.
7. Veale D. Over-valued ideas: a conceptual analysis. Behav Res Ther. 2002; 40: 383-400.
8. Walker C. Delusion: What Did Jaspers Really Say? B J Psych. 1991; 159 (suppl. 14): 94-103.
9. Brakoulias V, Starcevic V. The Characterisation of Beliefs in Obsessive-Compulsive Disorder. Psychiatr Q. 2011; 82: 151-161.
10. Ecker W. Non-delusional pathological jealousy as an obsessive-compulsive spectrum disorder: Cognitive-behavioural conceptualization and some treatment suggestions. J Obsessive Compuls Relat Disord. 2012; 1: 203-210.

11. Yaryura-Tobias JA. An Overview on Delusions, Obsessions and Overvalued Ideas. An Intimate Cluster of Thought Pathology. Clin Neuropsychiatry. 2004; 1(1): 5-12.
12. Berrios G. Delusions as “wrong beliefs”: A conceptual history. B J Psych. 1991; 159 (suppl 14): 6–1.
13. Mullen R, Gillet G. Delusions: A Different Kind of Belief? Philos Psychiatr Psychol. 2014 March; 21(1): 27-37.
14. Jaspers K. General Psychopathology (English translation). Manchester: Manchester University Press; 1963.
15. Casey F, Kelly B. Fish’s Clinical Psychopathology. 3rd Edition. London, United Kingdom: RCPsych Publications; 2007.
16. McKenna PJ. Disorders with Overvalued Ideas. B J Psych. 1984; 145: 579-585.
17. Oyebode F. Sims’ Symptoms in the Mind. 5th Edition. London, United Kingdom: Elsevier Health Sciences; 2015.
18. Mishara AL, Fusar-Poli P. The Phenomenology and Neurobiology of Delusion Formation During Psychosis Onset: Jaspers, Truman Symptoms, and Aberrant Silence. Schizophr Bull. 2013; 39(2): 278-286.
19. Mullen R, Linscott RJ. A Comparison of Delusions and Overvalued Ideas. J Nerv Ment Dis. 2010; 198: 35-38.
20. McKenna PJ. Schizophrenia and Related Syndromes. 2nd Edition. United Kingdom; Oxford University Press: 2007.
21. Hamilton M. Fish’s Clinical Psychopathology. Revised Edition. Bristol, United Kingdom: John Wright; 1974.

22. Insel TR. Phenomenology of Obsessive-Compulsive Disorder. J Clin Psychiatry. 1990; 51(suppl. 2): 4-8.
23. Burgy M. Obsession in the Strict Sense: A Helpful Psychopathological Phenomenon in the Differential Diagnosis between Obsessive-Compulsive Disorder and Schizophrenia. Psychopathology. 2007; 40: 102-110.
24. Spitzer M, Sigmund D. The phenomenology of obsessive-compulsive disorder. Int J Psychiatry. 1997; 9: 7-13.
25. Pollitt J. Discussion: obsessive compulsive states (abridged). Proc R Soc Med. 1956; 49: 842-845.
26. Shavitt RG, de Mathis MA, Oki F, Ferrao YA, Fontenelle LF, Torres AR, Diniz JB, Costa DLC, do Rosario MC, Hoexter MQ, Miguel EC, Simpson HB. Phenomenology of OCD: Lessons from a large multicenter study and implications for ICD-11. J Psychiatr Res. 2014; 57: 141-18.
27. Blom RM, Hagestein-de Bruijn C, de Graaf R, ten Have M, Denys DA. Obsessions in Normality and Psychopathology. Depress Anxiety. 2011; 28: 870-875.
28. Mullen R. Delusions: the continuum versus category debate. Aust N Z J Psychiatry. 2003; 37: 505-511.
29. Mountjoy RL, Farhall JF, Rossell SL. A phenomenological investigation of overvalued ideas and delusions in clinical and subclinical anorexia nervosa. Psychiatry Res. 2014 Aug: 1-6.
30. Ghaemi SN. An Empirical Approach to Understanding Delusions. Philos Psychiatr Psychol.1999 Mar; 6(1): 21-24.
31. Lopez-Santin JM, Molins Galvez F. Overvalued ideas: psychopathologic issues. Actas Esp Psiquiatr. 2011; 39(1): 70-74.

32. Neziroglu F, McKay D, Yaryura-Tobias JA, Stevens KP, Todaro J. The overvalued ideas scale: development, reliability and validity in obsessive-compulsive disorder. Behav Res Ther. 1997; 37: 881-902.
33. Insel TR, Akiskal HS. Obsessive-Compulsive Disorder With Psychotic Features: A Phenomenologic Analysis. Am J Psychiatry. 1986; 143(12): 1527-1533.
34. Fountoulakis KN, Andreoulakis IE, Iacovides A. Nonsensory Hallucinations or Obsessive Symptoms? J Nerv Ment Dis. 2013; 201(9): 818-823.
35. Phillips KA, Kim JM, Hudson JI. Body Image Disturbance in Body Dysmorphic Disorder and Eating Disorders. Psychiatr Clin North Am. 1995; 18(2): 317-334.
36. Markova IS, Jaafari N, Berrios GE. Insight and Obsessive-Compulsive Disorder: A Conceptual Analysis. Psychopathology. 2009; 42: 277-282.
37. Hartmann AS, Thomas JJ, Wilson AC, Wilhelm S. Insight impairment in body image disorders: Delusionality and overvalued ideas in anorexia nervosa versus body dysmorphic disorder. Psychiatry Res. 2013; 210: 1129-1135.
38. Strauss J. Hallucinations and delusions as points on continua function: rating scale evidence. Arch Gen Psychiatr. 1969; 21: 581–586.
39. Taylor FK. Psychopathology: Its causes and symptoms. Sunbury-on-Thames: Quartermarine House; 1979.
40. Moor JH, Tucker GJ. Delusions: Analysis and criteria. Compr Psychiatry. 1979; 20: 388-393.
41. Sanders J, Whitty P, Murray D, Devitt P. Delusions or Obsessions: The Same Only Different? Psychopathology. 2006; 39: 45-48.

42. Oulis P, Konstantakopoulos G, Lykouras L, Michalopoulou PG. Differential diagnosis of obsessive-compulsive symptoms from delusions in schizophrenia: A phenomenological approach. World J Psychiatr. 2013 Sep; 3(3): 50-56.
43. Eisen JL, Phillips KA, Baer L, Beer DA, Atala KD, Rasmussen SA. The Brown Assessment of Beliefs Scale: Reliability and Validity. Am J Psychiatry. 1998; 155: 102-108.
44. de Haan S, Rietveld E, Deny D. On the Nature of Obsessions and Compulsions. Mod Trends Pharmacopsychiatry. 2013; 29: 1-15.
45. Batinic B, Duisin D, Barisic J. Obsessive Versus Delusional Jealousy. Psychiatria Danubina. 2013; 25(3): 334-339.