1. a disorder of the mind in which the sufferer has intrusive irrational thoughts and engages in repetitive rituals to find temporary relief.

Summary Article: Obsessive-Compulsive Disorder
From Encyclopedia of Global Health

Obsessive-compulsive disorder is a chronic, disabling anxiety disorder characterized by intrusive, persistent thoughts and repetitive behaviors. Obsessions may include recurrent thoughts, images, or impulses that cause distress or anxiety such as aggressive thoughts, fears of germs or dirt, fears of social embarrassment, or fears that others may be in danger. Although healthy people exhibit compulsive behavior (e.g., checking to make sure the iron is turned off), individuals with obsessive-compulsive disorder have compulsive rituals that are performed to neutralize or combat these fears; these compulsions are not pleasurable, often end up controlling the individual, and may interfere with his or her daily life. Notwithstanding the emotional burden to the individual and his or her family, total lifetime indirect costs of obsessive-compulsive disorder are estimated at $40 billion.

DIAGNOSTIC CRITERIA
The Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), published by the American Psychiatric Association, establishes five diagnostic criteria used by clinicians in diagnosing obsessive-compulsive disorder. First, the individual must have either obsessions or compulsions described as follows: obsessions are recurrent, persistent thoughts that are intrusive and cause marked anxiety. These thoughts and images are not merely excessive worrying about “real” problems and originate from the individual. The individual makes an attempt to suppress the thoughts and images with another action. Compulsions are defined as repetitive behaviors or mental acts that an individual feels compelled to perform in response to an obsession even though the acts are not connected in a clear way to the obsession. Second, the person comes to the realization at some point in the course of the disorder that his or her behaviors are excessive. Third, the obsessions and compulsions become time consuming and significantly disrupt routine activities. Finally, the obsessive-compulsive behavior is not limited to another Axis I diagnosis if present nor is the behavior directly linked to the effects of another substance (e.g., drugs or medication).

EPIDEMIOLOGY, CAUSE, AND CLINICAL FEATURES
Obsessive-compulsive disorder affects over 2 million adult Americans and has a lifetime prevalence of 2 to 3 percent in the United States. These rates are consistent with those in Europe, Africa, Canada, and the Middle East, while estimated rates in Asian countries are slightly lower.

Although obsessive-compulsive disorder is a lifetime illness, its prevalence in young adults is twice that seen in older adults. Obsessive-compulsive disorder often appears in childhood, adolescence, or young
adulthood and may be accompanied by other anxiety disorders such as eating disorders. In fact, disorders whose features are shared with obsessive-compulsive disorder (e.g., somatoform disorders, neurologic disorders, eating disorders, and impulse control disorders) have been categorized as "obsessive-compulsive spectrum disorders."

Obsessive-compulsive disorder affects men and women in different proportions, depending on the age of onset. Of those individuals whose onset is in childhood or early adolescence, males are disproportionately affected. Women have a slightly higher prevalence of obsessive-compulsive disorder in the adult population.

Specific obsessions that occur commonly in obsessive-compulsive disorder include contamination fears and pathological doubt (irrational fears that something is wrong). The need for symmetry, fears of endangerment to self or to others, and sexual concerns occur less often.

Individuals with obsessive-compulsive disorder experience a significant drop in the quality of their lives attributed to the acute shame, distress, and the amount of time devoted to acting out their compulsive behaviors. Social, familial, and professional relationships are impaired as individuals with obsessive-compulsive disorder may miss appointments, meetings, and scheduled gatherings due to their rituals.

Diagnosing obsessive-compulsive disorder may be difficult due to a reluctance to seek treatment and thereby disclose their symptoms out of fear that they will be considered “crazy,” thus putting the onus on physicians to screen actively for obsessive-compulsive disorder in their patients. Examples of screening questions may include “Are there certain thoughts that go through your mind over and over that you cannot get rid of?” or “Are there behaviors or habits that you feel compelled to repeat?”

Over the years, major etiologic theories of obsessive-compulsive disorder have included those that are described as psychoanalytic, cognitive, traumatic, and genetic. It is no longer thought that obsessive-compulsive disorder arises from psychic trauma or from psychoanalytic origin. The observation that obsessive-compulsive disorder occurs with higher frequency in first-degree family members as compared to the general population has sparked interest in research in genetic models for this disorder. Obsessive-compulsive disorder has been linked to a gene responsible for the tics and obsessive-compulsive disorder behavior found in Tourette’s syndrome. Although causality has yet to be established, imaging studies also have implicated the prefrontal cortex, cingulate gyrus, and basal ganglia in this disorder, and the neurotransmitter serotonin is thought to play a role in the pathogenesis as well.

**OUTCOMES AND TREATMENT**

In one long-term study of individuals with obsessive-compulsive disorder, only one-fifth of the study participants experienced a full remittance of their disorder. However, two-thirds described some improvement 10 years postdiagnosis. Treatment of individuals with obsessive-compulsive disorder can be challenging due to the frequent relapse rate, but both psychotherapy (behavioral therapy) and drug therapy may be useful forms of treatment.

Behavioral therapy for obsessive-compulsive disorder includes both exposure and response prevention, and cognitive therapy. This is built around the premise that anxiety will dissipate with increased contact with the triggering stimulus. However, chronic exposure is not enough; the compulsions will remain if not specifically addressed. Therefore, the clinician guides the individual through experiencing the aversive condition while refraining from performing the compulsion.
Pharmacological treatment is recommended for most individuals with obsessive-compulsive disorder, and among the preferential serotonergic reuptake inhibitors which include fluoxetine (also known as Prozac®), clomipramine has been the primary therapy for years. However, its side effects have been severe: weight gain, drowsiness, anticholinergic effects. Later research describes other selective serotonin reuptake inhibitors (SSRIs) as superiorly effective to clomipramine, although treated individuals frequently complain of unwanted sexual side effects a few weeks into pharmacotherapy. There is no cure for obsessive-compulsive disorder.

**CURRENT RESEARCH**

Pregnant and postpartum women appear to be at particular risk of developing obsessive-compulsive disorder. Limited research reveals that the obsessive thoughts these women have pertain to harming the baby, fears of sexually abusing the baby, and again, contamination fears. With exception to the last, acting on these obsessions has been rare; nevertheless, this finding warrants attention. In response to fears about contamination, postpartum women may avoid changing the baby, allowing it to crawl on floors, or compulsively washing the baby’s bottles. If left untreated, obsessive-compulsive disorder in pregnant women may worsen after she gives birth.

**SEE ALSO:**
Mental Health; Postpartum Depression; Psychiatry.

**BIBLIOGRAPHY**
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