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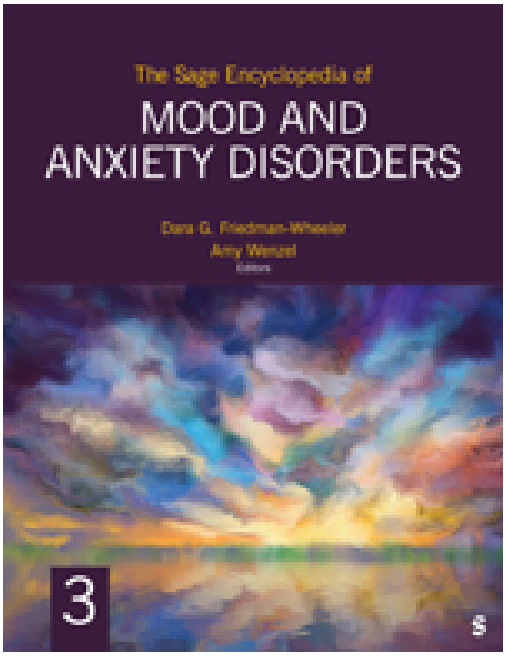

Sage Reference

The Sage Encyclopedia of Mood and Anxiety Disorders

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Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is a psychiatric condition defined by covert symptoms that present as intrusive thoughts, urges, or ideas surrounding clustered obsessions and compulsions causing significant distress and impairment in a person's daily life. Obsessive symptoms are recurrent, persistent, and invasive, typically followed by compulsive, ritualistic behaviors or mental acts that feel necessary to minimize stress and anxiety. OCD has a lifetime prevalence of ~3% globally, with women being approximately twice as likely as men to develop OCD, but the condition is frequently misunderstood and misdiagnosed, often on account of cultural differences. A later onset of symptoms can be seen for women than for men, who may show symptoms as young children or adolescents. This entry explains OCD diagnostic criteria and different subtypes, describes epidemiology and sociocultural aspects, outlines etiology, presents treatment options, and concludes with an overview of related disorders.

Diagnosis

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* criteria for diagnosing OCD, an individual must experience repeated obsessions *or* compulsions that are significantly time consuming and interfere with functioning. However, evidence does suggest that individuals with diagnosable OCD do experience both obsessions *and* compulsions. Symptoms also should not be attributed to another medical condition or substance use or mental disorder. Due to the extremely distressing nature of the obsessive, overwhelming thoughts, compulsive acts are performed as a form of suppression, or neutralization, to reduce anxiety quickly yet temporarily. This eventually exacerbates symptoms over time. Resisting urges leads to increasing anxiety, reinforcing compulsions and creating a ritualistic cycle, emphasizing the need for early intervention. Along with immense distress, high levels of depression, self-blame, and hopelessness are consistent with OCD as well as a reduced quality of life.

To diagnose OCD, most experts stress use of the Yale–Brown Obsessive-Compulsive Scale, a semi-structured clinical interview that is considered to be the gold standard for measuring the severity of OCD. According to this measure, there are several different presentations of OCD obsessions and compulsions that can be categorized into subgroups such as forbidden or taboo, symmetry, cleaning, and harm. Forbidden or taboo thoughts may encompass religious, aggressive, or sexual ideals. Symmetry OCD presents as repeating, counting, or reorganizing compulsions to subdue superstitious thoughts or uncommon worries. Cleaning compulsions are often a result of contamination obsessions (e.g., bacteria and viruses), which can be a fre-

quent consequence of a related trauma. Harm OCD stems from the fear of inadvertently harming oneself or others, usually followed by excessive checking compulsions, such as repeatedly making sure that a door is locked before leaving one's dwelling or office.

Whereas OCD occurs in many different forms, these are all defined by similar cognitive themes: inflated responsibility over one's own or others' safety, the belief that weight of thought is equivalent to an action, concerns over being unable to control thoughts, overestimation of threats or risks, intolerance of uncertainty, and justification. Consequently, exaggerated risk aversions and increasingly negative self-outlook are often seen. Individuals with OCD are at higher risk of developing major depression, substance use disorders, eating disorders, and other anxiety-related disorders.

Epidemiology and Sociocultural Aspects

The expression of OCD is heavily influenced by cultural and social factors. Different cultures have unique beliefs, values, and norms related to mental health, affecting how they perceive, discuss, and experience OCD symptoms. Statistically, OCD has been found globally across cultures, although people of color are drastically underrepresented for specialized OCD care. Differences in race, ethnicity, and culture can make working with clients with OCD quite challenging if one lacks awareness of these factors or of one's own personal biases. It is essential that treating clinicians recognize these cultural differences and acknowledge the marginalization and stigmatization some of their clients face, whether it is based on religion, race/ethnicity, gender, or sexuality. With OCD, specific obsessions and compulsions can be deemed more shameful depending on the culture. People of color are more likely to experience stigmas surrounding mental health or may be more unwilling to share their symptoms due to fear of stereotyping, thereby imposing barriers to care. For this reason, diagnostic assessments must be carried out with an awareness of cultural specificities to establish an accurate diagnosis and foster a safe, open environment for communication. It is important to note that numerous standard OCD measures, both self-reports and clinical interviews, have not been tested often with diverse populations and may not as accurately encapsulate their diagnosis. Emphasizing the normality of symptoms as characteristics of OCD with respect to their culture can reduce any negative feelings such as fear or humiliation, increase client retention rates, and strengthen the therapeutic relationship.

Studies have shown that in countries such as the United States, the United Kingdom, and Canada, women are almost two times more likely than men to develop OCD, with symptoms presenting usually after ado-

lescence for women and in in early adolescence for men. Men also report having more compulsions than women. The average age of onset is 18 to 20 years of age, with about a quarter of people experiencing onset at about age 14 years. In these societies, research indicates that there are clear roles in types of OCD, with men often experiencing checking OCD types and women enduring cleaning OCD types. Gender differences in contamination and taboo types of OCD were not present among Blacks. However, it was found that Blacks, Asian Americans, and Latinx Americans experience contamination OCD symptoms more often than do European Americans. Yet, the lack of OCD treatment in these populations is possibly because they are seeking other forms of treatment for their symptoms. A theory explaining this may be due to the historical evidence of European Americans expressing concerns of being contaminated by other racial and ethnic groups, resulting in people of color overcompensating in cleanliness. Contamination OCD also was very prominent in Latinx population studies as well as obsessions surrounding symmetry, danger, and aggression. Perfectionism, a common OCD subtype, is most prevalent in Asian American communities, potentially because of the expectations for high achievement in many traditional Asian cultures.

Owing to the disproportionate prevalence of specific OCD subtypes in ethnic/racial groups, the influence of stigma and oppression on symptoms must be carefully considered. For example, Blacks report animal-related obsessions and compulsions two times more than European Americans do, perhaps due to the historical use of animal attacks on slaves and civil rights activists. Having a culturally sensitive perspective as a therapist allows for precise treatment planning and ultimately improved treatment outcomes. Cross-cultural awareness, allyship, recognizing multifaceted identities, and having specialized knowledge across race, ethnicity, and culture are of particular importance in efforts to treat OCD effectively.

Etiology

With a complex etiology, OCD has been shown to have genetic, biological, and environmental factors. Those with a family genetic predisposition to OCD are at higher risk of developing it as well. Biologically, OCD affects the cortical–striatal–thalamic circuit, which controls how a person responds to their primal, unmediated behaviors or impulses, due to an imbalance in serotonin levels. This circuit is hyperactive in those with OCD, making it hard for a person to dismiss such intrusive impulses, thoughts, or behaviors. For example, a person diagnosed with OCD may become fixated on continual handwashing because of contamination concerns, unable to subdue these worries, whereas someone with no symptoms may feel satisfied after one wash.

Environmentally, OCD may be triggered in susceptible individuals through a traumatic or stressful life event, especially if it occurred in childhood. Intrusive thoughts surrounding said event can cause self-blame in an individual and a belief that their actions will result in negative outcomes. Consequently, a person may attempt to neutralize these feelings through specific behaviors, actions, or thoughts that offer temporary relief of distress but reinforce the action encouraging continuous compulsions. Over time, the fear of intrusive thoughts increases, causing the thoughts to appear more frequently and become an obsession. Individuals diagnosed with OCD report intrusive thoughts and using neutralization techniques to reduce anxiety more frequently than do others. It is believed that individuals with OCD maintain high standards of morality, equate thoughts with actions, and feel a strong need for control. People with these characteristics may be more prone to developing OCD.

Treatment

OCD has a chronic symptomatic course if not treated properly. A number of treatment options are available for individuals with OCD. One of the most effective treatments for OCD is exposure and response prevention therapy (or exposure and ritual prevention [ERP]). ERP is a cognitive behavioral therapy that incrementally exposes individuals to anxiety-inducing ideas or situations while simultaneously mitigating the development of compulsions. Ultimately, this process will cause habituation to the distressing thoughts and significantly lessen the urge to perform compulsive acts. Having self-awareness and recognizing that obsessions are intrusive and not indicative of one's true self, along with understanding that compulsions are unnecessary, plays a crucial role in the success of ERP.

Clinicians may choose between two kinds of exposures in treatment: in vivo or imaginary exposures. In vivo exposures involve real-life actions related to obsessions. For example, a clinician may instruct a person with contamination fears to dig a hole with their bare hands and resist washing them immediately afterward. Imaginary exposures consist of vividly imagining avoided thoughts and obsessions. For instance, a clinician may have a person with contamination fears imagine they have eaten a cookie picked up from a dirty floor. The kind of exposure chosen depends on the therapist's discretion and individual symptom presentation. Treatment can be relatively short term if it is kept up with properly, resulting in diminished symptoms in only a few days with ERP. Treatment may need adjustments based on an individual's culture and race as well. It is vital to respect the client's culture, race, religion, and gender when creating exposures. Strengthening the thera-

peutic relationship and creating a safe space for the client are essential and can be accomplished through functional analytic psychotherapy. Some research supports using functional analytic psychotherapy supplemental to the use of ERP in the Latinx community and suggests potential use when treating other marginalized groups. This can be uniquely done by working in vivo on specific client–therapist interactions that allow in-the-moment opportunities for clients to challenge their OCD behaviors and ultimately change them for the better. Functional analytic psychotherapy actually can enhance their effectiveness by providing a more natural relational approach to therapy.

If therapeutic methods prove to be insufficient, a psychiatrist may prescribe antidepressants, such as selective serotonin reuptake inhibitors, to regulate serotonin and reduce symptoms. However, medication does not always benefit everyone with OCD and, in fact, may only mask symptoms. It is also not a first-line option when dealing with OCD in children because it can result in changes in their brain structure. It should be noted that white individuals are more likely than people of color to receive counseling for OCD, whether it be cognitive behavioral therapy or talk therapy.

OCD-Related Disorders

OCD serves as an umbrella term in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, to encompass its related disorders as well as those that have similar covert symptom presentations but look different overtly. These disorders include hoarding disorder, body dysmorphic disorder, trichotillomania, excoriation disorder, panic disorder, specific phobias, and agoraphobia, which likely require different treatments. Clinicians must carefully assess symptoms so as not to mistake them for something that may seem indistinguishable from OCD. Illness anxiety disorder, however, is considered by many experts to be the same as OCD.

See also Agoraphobia; Body Dysmorphic Disorder; Exposure and Response Prevention; Generalized Anxiety Disorder; Health Anxiety; Hoarding; Imaginal Exposure; In Vivo Exposure; Major Depressive Disorder; Panic Disorder; Phobia; Trichotillomania

Further Readings

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