Subject Name	**Subject Code**	**Prepared by**
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OBSESSIVE COMPULSIVE DISORDER

Obsessive-compulsive disorder (OCD) is the anxiety disorder characterized by one or more obsessions, which may occur together with compulsions.

Obsessions are thoughts, impulses, or images that persist or recurare intrusive—and therefore difficult to ignore—and are inappropriate to the situation.

Compulsions are repetitive behaviours or mental acts that a person feels driven to carry out and that usually correspond thematically to an obsession. The obsession can cause great distress and anxiety, despite a person's attempts to ignore or drive out the intrusive thoughts

Type of Obsession	**Examples of obsessions:** People with OCD may be preoccupied with anxiety-inducing thoughts about . . .	Type of Compulsion
Contamination	germs, dirt	Washing
Order	objects being disorganized, or a consuming desire to have objects or situations conform to a particular order or alignment	Ordering
Losing control	the possibility of behaving impulsively or aggressively, such as yelling during a funeral	Counting
Doubt	whether an action, such as turning off the stove, was performed	Checking
Possible need	the extremely remote likelihood that they will need a particular object at some undetermined point in the future as part of some unknown need (for instance, that they might need to look up something in today's newspaper in a few years)	Hoarding

People with OCD recognize that their obsessive thoughts do not originate

from an external source—for example, the thoughts aren't implanted by aliens from outer space, as some people with psychotic symptoms believe. Instead, they realize that the thoughts arise in their own minds, even though they can't control or suppress the thoughts. Symptoms build gradually until they reach a level that meets the diagnostic criteria. Over the course of a lifetime, symptoms wax and wane, becoming particularly evident in response to stress.

DSM-IV-TR DIAGNOSTIC CRITERIA

A. Either obsessions or compulsions:
Obsessions as defi ned by (1), (2), (3), and (4):

(1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems

(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action

(4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind

Compulsions as defi ned by (1) and (2):

(1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

(2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.

C. The obsessions or compulsions cause marked distress, are time consuming(take more than 1 hour a day), or signifi cantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it

E. The disturbance is not due to the direct physiological effects of a substance or a general medical condition.

CAUSAL FACTORS

- Neurological factors associated with OCD include disruptions in the normal activity of the frontal lobes, the thalamus, and the basal ganglia; lower than normal levels of serotonin; and genetic vulnerabilities.

- Psychological factors include negative reinforcement of the compulsive behaviour, which temporarily relieves the anxiety that arises from the obsession and cognitive biases related to the theme of obsessions.

- Social factors include socially induced stress, which can influence the onset and course of the disorder, and culture, which can influence the particular content of obsessions and compulsions.

TREATMENT

- Medication (such as an SSRI or clomipramine)

- The primary treatment for OCD is exposure with response prevention. Cognitive restructuring to reduce the irrationality and frequency of the patient's intrusive thoughts and obsessions may also be employed.

- Family education or therapy targets social factors

BODY DYSMORPHIC DISORDER

Body dysmorphic disorder (sometimes called dysmorphophobia) is diagnosed when someone is excessively preoccupied with a perceived defect or defects in appearance. The preoccupation is excessive because a defect is either

imagined or slight. Common preoccupations for people with body dysmorphic disorder are thinning or excessive hair, acne, wrinkles, scars, complexion (too pale, too dark, too red, and so on), facial asymmetry, or the shape or size of some part of the face or body. The "defect" (or "defects") may change over the course of the illness. Body dysmorphic disorder usually begins in adolescence, but it can go undiagnosed for several years if the person does not discuss the symptoms with anyone.

People with body dysmorphic disorder may think that others are staring at them or talking about a "defect." They may compulsively exercise, diet, shop for beauty aids, pick at their skin, try to hide perceived defects, or spend hours looking in the mirror. Alternatively, people with body dysmorphic disorder may try to avoid mirrors altogether. The preoccupation with—or attempts to hide—a perceived defect can be difficult to control and therefore devastating, consuming up to 8 hours each day. An individual with body dysmorphic disorder may seek reassurance ("How do I look?"), but any positive effects of reassurance are transient; a half-hour later, he or she may ask the same question—even to the same person. Unfortunately, these behaviours, which are intended to decrease anxiety about appearance, end up increasing anxiety.

DSM-IV-TR DIAGNOSTIC CRITERIA

A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive.

B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

C. The preoccupation is not better accounted for by another mental disorder.

Individuals who have body dysmorphic disorder may feel so selfconscious about a perceived defect that they avoid social situations, which results in their having few (or no) friends nor a romantic partner. Some try to get medical or surgical treatment for a "defect," such as plastic surgery, dental work, or dermatological treatment. But surgery often does not help; in fact, the symptoms of the disorder can actually be worse after surgery. In extreme cases, when some people with body dysmorphic disorder can't find a doctor to perform the treatment they think they need, they may try to do it themselves. Research on body dysmorphic disorder has focused on psychological factors, particularly cognitive biases and catastrophic thinking (along with symptom amplification and bodily preoccupation).A patient's perceived defect tends to be related to bodily attributes that are highly valued in his or her culture or subculture.