Obsessive-Compulsive Disorder

Diagnostic Criteria **300.3 (F42)**

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined 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 individual 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 anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

   Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).

Specify if:

With good or fair insight: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true.

With absent insight/delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Specify if:

Tic-related: The individual has a current or past history of a tic disorder.

Specifiers

Many individuals with obsessive-compulsive disorder (OCD) have dysfunctional beliefs. These beliefs can include an inflated sense of responsibility and the tendency to overestimate threat; perfectionism and intolerance of uncertainty; and over-importance of thoughts (e.g., believing that having a forbidden thought is as bad as acting on it) and the need to control thoughts.

Individuals with OCD vary in the degree of insight they have about the accuracy of the beliefs that underlie their obsessive-compulsive symptoms. Many individuals have *good or fair insight* (e.g., the individual believes that the house definitely will not, probably will not, or may or may not burn down if the stove is not checked 30 times). Some have *poor insight* (e.g., the individual believes that the house will probably burn down if the stove is not checked 30 times), and a few (4% or less) have *absent insight/delusional beliefs* (e.g., the individual is convinced that the house will burn down if the stove is not checked 30 times). Insight can vary within an individual over the course of the illness. Poorer insight has been linked to worse long-term outcome.

Up to 30% of individuals with OCD have a lifetime tic disorder. This is most common in males with onset of OCD in childhood. These individuals tend to differ from those without a history of tic disorders in the themes of their OCD symptoms, comorbidity, course, and pattern of familial transmission.

Diagnostic Features

The characteristic symptoms of OCD are the presence of obsessions and compulsions (Criterion A). *Obsessions* are repetitive and persistent thoughts (e.g., of contamination), images (e.g., of violent or horrific scenes), or urges (e.g., to stab someone). Importantly, obsessions are not pleasurable or experienced as voluntary: they are intrusive and unwanted and cause marked distress or anxiety in most individuals. The individual attempts to ignore or suppress these obsessions (e.g., avoiding triggers or using thought suppression) or to neutralize them with another thought or action (e.g., performing a compulsion). *Compulsions* (or rituals) are repetitive behaviors (e.g., washing, checking) or mental acts (e.g., counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly. Most individuals with OCD have both obsessions and compulsions. Compulsions are typically performed in response to an obsession (e.g., thoughts of contamination leading to washing rituals or that something is incorrect leading to repeating rituals until it feels "just right"). The aim is to reduce the distress triggered by obsessions or to prevent a feared event (e.g., becoming ill). However, these compulsions either are not connected in a realistic way to the feared event (e.g., arranging items symmetrically to prevent harm to a loved one) or are clearly excessive (e.g., showering for hours each day). Compulsions are not done for pleasure, although some individuals experience relief from anxiety or distress.

Criterion B emphasizes that obsessions and compulsions must be time-consuming (e.g., more than 1 hour per day) or cause clinically significant distress or impairment to warrant a diagnosis of OCD. This criterion helps to distinguish the disorder from the occasional intrusive thoughts or repetitive behaviors that are common in the general population (e.g., double-checking that a door is locked). The frequency and severity of obsessions and compulsions vary across individuals with OCD (e.g., some have mild to moderate symptoms, spending 1–3 hours per day obsessing or doing compulsions, whereas others have nearly constant intrusive thoughts or compulsions that can be incapacitating).

Associated Features Supporting Diagnosis

The specific content of obsessions and compulsions varies between individuals. However, certain themes, or dimensions, are common, including those of cleaning (contamination obsessions and cleaning compulsions); symmetry (symmetry obsessions and repeating,

ordering, and counting compulsions); forbidden or taboo thoughts (e.g., aggressive, sexual, or religious obsessions and related compulsions); and harm (e.g., fears of harm to oneself or others and checking compulsions). Some individuals also have difficulties discarding and accumulate (hoard) objects as a consequence of typical obsessions and compulsions, such as fears of harming others. These themes occur across different cultures, are relatively consistent over time in adults with the disorder, and may be associated with different neural substrates. Importantly, individuals often have symptoms in more than one dimension.

Individuals with OCD experience a range of affective responses when confronted with situations that trigger obsessions and compulsions. For example, many individuals experience marked anxiety that can include recurrent panic attacks. Others report strong feelings of disgust. While performing compulsions, some individuals report a distressing sense of "incompleteness" or uneasiness until things look, feel, or sound "just right."

It is common for individuals with the disorder to avoid people, places, and things that trigger obsessions and compulsions. For example, individuals with contamination concerns might avoid public situations (e.g., restaurants, public restrooms) to reduce exposure to feared contaminants; individuals with intrusive thoughts about causing harm might avoid social interactions.

Prevalence

The 12-month prevalence of OCD in the United States is 1.2%, with a similar prevalence internationally (1.1%–1.8%). Females are affected at a slightly higher rate than males in adulthood, although males are more commonly affected in childhood.

Development and Course

In the United States, the mean age at onset of OCD is 19.5 years, and 25% of cases start by age 14 years. Onset after age 35 years is unusual but does occur. Males have an earlier age at onset than females: nearly 25% of males have onset before age 10 years. The onset of symptoms is typically gradual; however, acute onset has also been reported.

If OCD is untreated, the course is usually chronic, often with waxing and waning symptoms. Some individuals have an episodic course, and a minority have a deteriorating course. Without treatment, remission rates in adults are low (e.g., 20% for those reevaluated 40 years later). Onset in childhood or adolescence can lead to a lifetime of OCD. However, 40% of individuals with onset of OCD in childhood or adolescence may experience remission by early adulthood. The course of OCD is often complicated by the co-occurrence of other disorders (see section "Comorbidity" for this disorder).

Compulsions are more easily diagnosed in children than obsessions are because compulsions are observable. However, most children have both obsessions and compulsions (as do most adults). The pattern of symptoms in adults can be stable over time, but it is more variable in children. Some differences in the content of obsessions and compulsions have been reported when children and adolescent samples have been compared with adult samples. These differences likely reflect content appropriate to different developmental stages (e.g., higher rates of sexual and religious obsessions in adolescents than in children; higher rates of harm obsessions [e.g., fears of catastrophic events, such as death or illness to self or loved ones] in children and adolescents than in adults).

Risk and Prognostic Factors

Temperamental. Greater internalizing symptoms, higher negative emotionality, and behavioral inhibition in childhood are possible temperamental risk factors.

Environmental. Physical and sexual abuse in childhood and other stressful or traumatic events have been associated with an increased risk for developing OCD. Some children

may develop the sudden onset of obsessive-compulsive symptoms, which has been associated with different environmental factors, including various infectious agents and a post-infectious autoimmune syndrome.

Genetic and physiological. The rate of OCD among first-degree relatives of adults with OCD is approximately two times that among first-degree relatives of those without the disorder; however, among first-degree relatives of individuals with onset of OCD in childhood or adolescence, the rate is increased 10-fold. Familial transmission is due in part to genetic factors (e.g., a concordance rate of 0.57 for monozygotic vs. 0.22 for dizygotic twins). Dysfunction in the orbitofrontal cortex, anterior cingulate cortex, and striatum have been most strongly implicated.

Culture-Related Diagnostic Issues

OCD occurs across the world. There is substantial similarity across cultures in the gender distribution, age at onset, and comorbidity of OCD. Moreover, around the globe, there is a similar symptom structure involving cleaning, symmetry, hoarding, taboo thoughts, or fear of harm. However, regional variation in symptom expression exists, and cultural factors may shape the content of obsessions and compulsions.

Gender-Related Diagnostic Issues

Males have an earlier age at onset of OCD than females and are more likely to have comorbid tic disorders. Gender differences in the pattern of symptom dimensions have been reported, with, for example, females more likely to have symptoms in the cleaning dimension and males more likely to have symptoms in the forbidden thoughts and symmetry dimensions. Onset or exacerbation of OCD, as well as symptoms that can interfere with the mother-infant relationship (e.g., aggressive obsessions leading to avoidance of the infant), have been reported in the peripartum period.

Suicide Risk

Suicidal thoughts occur at some point in as many as about half of individuals with OCD. Suicide attempts are also reported in up to one-quarter of individuals with OCD; the presence of comorbid major depressive disorder increases the risk.

Functional Consequences of Obsessive-Compulsive Disorder

OCD is associated with reduced quality of life as well as high levels of social and occupational impairment. Impairment occurs across many different domains of life and is associated with symptom severity. Impairment can be caused by the time spent obsessing and doing compulsions. Avoidance of situations that can trigger obsessions or compulsions can also severely restrict functioning. In addition, specific symptoms can create specific obstacles. For example, obsessions about harm can make relationships with family and friends feel hazardous; the result can be avoidance of these relationships. Obsessions about symmetry can derail the timely completion of school or work projects because the project never feels "just right," potentially resulting in school failure or job loss. Health consequences can also occur. For example, individuals with contamination concerns may avoid doctors' offices and hospitals (e.g., because of fears of exposure to germs) or develop dermatological problems (e.g., skin lesions due to excessive washing). Sometimes the symptoms of the disorder interfere with its own treatment (e.g., when medications are considered contaminated). When the disorder starts in childhood or adolescence, individuals may experience developmental difficulties. For example, adolescents may avoid socializing with peers; young adults may struggle when they leave home to live independently.

The result can be few significant relationships outside the family and a lack of autonomy and financial independence from their family of origin. In addition, some individuals with OCD try to impose rules and prohibitions on family members because of their disorder (e.g., no one in the family can have visitors to the house for fear of contamination), and this can lead to family dysfunction.

Differential Diagnosis

Anxiety disorders. Recurrent thoughts, avoidant behaviors, and repetitive requests for reassurance can also occur in anxiety disorders. However, the recurrent thoughts that are present in generalized anxiety disorder (i.e., worries) are usually about real-life concerns, whereas the obsessions of OCD usually do not involve real-life concerns and can include content that is odd, irrational, or of a seemingly magical nature; moreover, compulsions are often present and usually linked to the obsessions. Like individuals with OCD, individuals with specific phobia can have a fear reaction to specific objects or situations; however, in specific phobia the feared object is usually much more circumscribed, and rituals are not present. In social anxiety disorder (social phobia), the feared objects or situations are limited to social interactions, and avoidance or reassurance seeking is focused on reducing this social fear.

Major depressive disorder. OCD can be distinguished from the rumination of major depressive disorder, in which thoughts are usually mood-congruent and not necessarily experienced as intrusive or distressing; moreover, ruminations are not linked to compulsions, as is typical in OCD.

Other obsessive-compulsive and related disorders. In body dysmorphic disorder, the obsessions and compulsions are limited to concerns about physical appearance; and in trichotillomania (hair-pulling disorder), the compulsive behavior is limited to hair pulling in the absence of obsessions. Hoarding disorder symptoms focus exclusively on the persistent difficulty discarding or parting with possessions, marked distress associated with discarding items, and excessive accumulation of objects. However, if an individual has obsessions that are typical of OCD (e.g., concerns about incompleteness or harm), and these obsessions lead to compulsive hoarding behaviors (e.g., acquiring all objects in a set to attain a sense of completeness or not discarding old newspapers because they may contain information that could prevent harm), a diagnosis of OCD should be given instead.

Eating disorders. OCD can be distinguished from anorexia nervosa in that in OCD the obsessions and compulsions are not limited to concerns about weight and food.

Tics (in tic disorder) and stereotyped movements. A *tic* is a sudden, rapid, recurrent, nonrhythmic motor movement or vocalization (e.g., eye blinking, throat clearing). A *stereotyped movement* is a repetitive, seemingly driven, nonfunctional motor behavior (e.g., head banging, body rocking, self-biting). Tics and stereotyped movements are typically less complex than compulsions and are not aimed at neutralizing obsessions. However, distinguishing between complex tics and compulsions can be difficult. Whereas compulsions are usually preceded by obsessions, tics are often preceded by premonitory sensory urges. Some individuals have symptoms of both OCD and a tic disorder, in which case both diagnoses may be warranted.

Psychotic disorders. Some individuals with OCD have poor insight or even delusional OCD beliefs. However, they have obsessions and compulsions (distinguishing their condition from delusional disorder) and do not have other features of schizophrenia or schizoaffective disorder (e.g., hallucinations or formal thought disorder).

Other compulsive-like behaviors. Certain behaviors are sometimes described as "compulsive," including sexual behavior (in the case of paraphilias), gambling (i.e., gambling

disorder), and substance use (e.g., alcohol use disorder). However, these behaviors differ from the compulsions of OCD in that the person usually derives pleasure from the activity and may wish to resist it only because of its deleterious consequences.

Obsessive-compulsive personality disorder. Although obsessive-compulsive personality disorder and OCD have similar names, the clinical manifestations of these disorders are quite different. Obsessive-compulsive personality disorder is not characterized by intrusive thoughts, images, or urges or by repetitive behaviors that are performed in response to these intrusions; instead, it involves an enduring and pervasive maladaptive pattern of excessive perfectionism and rigid control. If an individual manifests symptoms of both OCD and obsessive-compulsive personality disorder, both diagnoses can be given.

Comorbidity

Individuals with OCD often have other psychopathology. Many adults with the disorder have a lifetime diagnosis of an anxiety disorder (76%; e.g., panic disorder, social anxiety disorder, generalized anxiety disorder, specific phobia) or a depressive or bipolar disorder (63% for any depressive or bipolar disorder, with the most common being major depressive disorder [41%]). Onset of OCD is usually later than for most comorbid anxiety disorders (with the exception of separation anxiety disorder) and PTSD but often precedes that of depressive disorders. Comorbid obsessive-compulsive personality disorder is also common in individuals with OCD (e.g., ranging from 23% to 32%).

Up to 30% of individuals with OCD also have a lifetime tic disorder. A comorbid tic disorder is most common in males with onset of OCD in childhood. These individuals tend to differ from those without a history of tic disorders in the themes of their OCD symptoms, comorbidity, course, and pattern of familial transmission. A triad of OCD, tic disorder, and attention-deficit/hyperactivity disorder can also be seen in children.

Disorders that occur more frequently in individuals with OCD than in those without the disorder include several obsessive-compulsive and related disorders such as body dysmorphic disorder, trichotillomania (hair-pulling disorder), and excoriation (skin-picking) disorder. Finally, an association between OCD and some disorders characterized by impulsivity, such as oppositional defiant disorder, has been reported.

OCD is also much more common in individuals with certain other disorders than would be expected based on its prevalence in the general population; when one of those other disorders is diagnosed, the individual should be assessed for OCD as well. For example, in individuals with schizophrenia or schizoaffective disorder, the prevalence of OCD is approximately 12%. Rates of OCD are also elevated in bipolar disorder; eating disorders, such as anorexia nervosa and bulimia nervosa; and Tourette's disorder.

Body Dysmorphic Disorder

Diagnostic Criteria **300.7 (F45.22)**

A. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.

B. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.

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

D. The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.

Specify if:

With muscle dysmorphia: The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. This specifier is used even if the individual is preoccupied with other body areas, which is often the case.

Specify if:

Indicate degree of insight regarding body dysmorphic disorder beliefs (e.g., "I look ugly" or "I look deformed").

With good or fair insight: The individual recognizes that the body dysmorphic disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight: The individual thinks that the body dysmorphic disorder beliefs are probably true.

With absent insight/delusional beliefs: The individual is completely convinced that the body dysmorphic disorder beliefs are true.

Diagnostic Features

Individuals with body dysmorphic disorder (formerly known as *dysmorphophobia*) are preoccupied with one or more perceived defects or flaws in their physical appearance, which they believe look ugly, unattractive, abnormal, or deformed (Criterion A). The perceived flaws are not observable or appear only slight to other individuals. Concerns range from looking "unattractive" or "not right" to looking "hideous" or "like a monster." Preoccupations can focus on one or many body areas, most commonly the skin (e.g., perceived acne, scars, lines, wrinkles, paleness), hair (e.g., "thinning" hair or "excessive" body or facial hair), or nose (e.g., size or shape). However, any body area can be the focus of concern (e.g., eyes, teeth, weight, stomach, breasts, legs, face size or shape, lips, chin, eyebrows, genitals). Some individuals are concerned about perceived asymmetry of body areas. The preoccupations are intrusive, unwanted, time-consuming (occurring, on average, 3–8 hours per day), and usually difficult to resist or control.

Excessive repetitive behaviors or mental acts (e.g., comparing) are performed in response to the preoccupation (Criterion B). The individual feels driven to perform these behaviors, which are not pleasurable and may increase anxiety and dysphoria. They are typically time-consuming and difficult to resist or control. Common behaviors are comparing one's appearance with that of other individuals; repeatedly checking perceived defects in mirrors or other reflecting surfaces or examining them directly; excessively grooming (e.g., combing, styling, shaving, plucking, or pulling hair); camouflaging (e.g., repeatedly applying makeup or covering disliked areas with such things as a hat, clothing, makeup, or hair); seeking reassurance about how the perceived flaws look; touching disliked areas to check them; excessively exercising or weight lifting; and seeking cosmetic procedures. Some individuals excessively tan (e.g., to darken "pale" skin or diminish perceived acne), repeatedly change their clothes (e.g., to camouflage perceived defects), or compulsively shop (e.g., for beauty products). Compulsive skin picking intended to improve perceived skin defects is common and can cause skin damage, infections, or ruptured blood vessels. The preoccupation must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C); usually both are present. Body dysmorphic disorder must be differentiated from an eating disorder.

Muscle dysmorphia, a form of body dysmorphic disorder occurring almost exclusively in males, consists of preoccupation with the idea that one's body is too small or insufficiently lean or muscular. Individuals with this form of the disorder actually have a normal-looking body or are even very muscular. They may also be preoccupied with other body areas, such as skin or hair. A majority (but not all) diet, exercise, and/or lift weights excessively, sometimes causing bodily damage. Some use potentially dangerous anabolic-

androgenic steroids and other substances to try to make their body bigger and more muscular. Body dysmorphic disorder by proxy is a form of body dysmorphic disorder in which individuals are preoccupied with defects they perceive in another person's appearance.

Insight regarding body dysmorphic disorder beliefs can range from good to absent/delusional (i.e., delusional beliefs consisting of complete conviction that the individual's view of their appearance is accurate and undistorted). On average, insight is poor; one-third or more of individuals currently have delusional body dysmorphic disorder beliefs. Individuals with delusional body dysmorphic disorder tend to have greater morbidity in some areas (e.g., suicidality), but this appears accounted for by their tendency to have more severe body dysmorphic disorder symptoms.

Associated Features Supporting Diagnosis

Many individuals with body dysmorphic disorder have ideas or delusions of reference, believing that other people take special notice of them or mock them because of how they look. Body dysmorphic disorder is associated with high levels of anxiety, social anxiety, social avoidance, depressed mood, neuroticism, and perfectionism as well as low extroversion and low self-esteem. Many individuals are ashamed of their appearance and their excessive focus on how they look, and are reluctant to reveal their concerns to others. A majority of individuals receive cosmetic treatment to try to improve their perceived defects. Dermatological treatment and surgery are most common, but any type (e.g., dental, electrolysis) may be received. Occasionally, individuals may perform surgery on themselves. Body dysmorphic disorder appears to respond poorly to such treatments and sometimes becomes worse. Some individuals take legal action or are violent toward the clinician because they are dissatisfied with the cosmetic outcome.

Body dysmorphic disorder has been associated with executive dysfunction and visual processing abnormalities, with a bias for analyzing and encoding details rather than holistic or configural aspects of visual stimuli. Individuals with this disorder tend to have a bias for negative and threatening interpretations of facial expressions and ambiguous scenarios.

Prevalence

The point prevalence among U.S. adults is 2.4% (2.5% in females and 2.2% in males). Outside the United States (i.e., Germany), current prevalence is approximately 1.7%–1.8%, with a gender distribution similar to that in the United States. The current prevalence is 9%–15% among dermatology patients, 7%–8% among U.S. cosmetic surgery patients, 3%–16% among international cosmetic surgery patients (most studies), 8% among adult orthodontia patients, and 10% among patients presenting for oral or maxillofacial surgery.

Development and Course

The mean age at disorder onset is 16–17 years, the median age at onset is 15 years, and the most common age at onset is 12–13 years. Two-thirds of individuals have disorder onset before age 18. Subclinical body dysmorphic disorder symptoms begin, on average, at age 12 or 13 years. Subclinical concerns usually evolve gradually to the full disorder, although some individuals experience abrupt onset of body dysmorphic disorder. The disorder appears to usually be chronic, although improvement is likely when evidence-based treatment is received. The disorder's clinical features appear largely similar in children/adolescents and adults. Body dysmorphic disorder occurs in the elderly, but little is known about the disorder in this age group. Individuals with disorder onset before age 18 years are more likely to attempt suicide, have more comorbidity, and have gradual (rather than acute) disorder onset than those with adult-onset body dysmorphic disorder.