DOWNLOAD PDF PROBLEMS ASSOCIATED WITH OBSESSIVE-COMPULSIVE DISORDER

Chapter 1 : International OCD Foundation | Disorders Related to (and sometimes confused with) OCD

Obsessive-Compulsive Disorder (OCD) is a common, chronic and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and behaviors (compulsions) that he or she feels the urge to repeat over and over.

Eating disorders are largely comorbid with OCD; [41] with some studies showing that OCD symptoms are nearly as severe among anorexics as among a classic OCD sample, and that this remains so even after discounting food- and weight-related obsessions and compulsions. The symptoms of both anorexics [43] and bulimics, [44] however, tend to be more restricted to symmetry and orderliness concerns. Delayed gratification was found to be pronounced among those with OCPD but not those with OCD only or the control samples, who had similar performances to one another. They may cause more problems in functioning than a major depressive episode. Under the genetic theory, people with a form of the DRD3 gene will probably develop OCPD and depression, particularly if they are male. Traumas that could lead to OCPD include physical, emotional, or sexual abuse, or other psychological trauma. Under the environmental theory, OCPD is a learned behavior. Further research is needed to determine the relative importance of genetic and environmental factors. DSM[edit] The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders DSM-5 , a widely used manual for diagnosing mental disorders , defines obsessiveâ€”compulsive personality disorder in Axis II Cluster C as an extensive pattern of preoccupation with perfectionism, orderliness, and interpersonal and mental control, at the cost of efficiency, flexibility and openness. Symptoms must appear by early adulthood and in multiple contexts. At least four of the following should be present: Shows perfectionism that interferes with task completion e. Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships not accounted for by obvious economic necessity. Is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values not accounted for by cultural or religious identification. Is unable to discard worn-out or worthless objects even when they have no sentimental value. Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things. Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes. Shows rigidity and stubbornness. A study challenged the usefulness of all but three of the criteria: It is characterized by at least four of the following:

DOWNLOAD PDF PROBLEMS ASSOCIATED WITH OBSESSIVE-COMPULSIVE DISORDER

Chapter 2 : Obsessive-compulsive disorder (OCD) - Symptoms and causes - Mayo Clinic

Obsessive-compulsive disorder (OCD) is an anxiety disorder characterized by uncontrollable, unwanted thoughts and ritualized, repetitive behaviors you feel compelled to perform. If you have OCD, you probably recognize that your obsessive thoughts and compulsive behaviors are irrationalâ€"but even so, you feel unable to resist them and break free.

People with OCPD will also feel a severe need to impose their own standards on their outside environment. People with OCPD have the following characteristics: They find it hard to express their feelings. They have difficulty forming and maintaining close relationships with others. They often feel righteous, indignant, and angry. They often face social isolation. They can experience anxiety that occurs with depression. They believe that their way of thinking and doing things is the only correct way and that everyone else is wrong. What are the causes of OCPD? The exact cause of OCPD is unknown. Like many aspects of OCPD, the causes have yet to be determined. OCPD may be caused by a combination of genetics and childhood experiences. In some case studies , adults can recall experiencing OCPD from a very early age. They may have felt that they needed to be a perfect or perfectly obedient child. This need to follow the rules then carries over into adulthood. Who is most at risk for OCPD? According to the Journal of Personality Assessment , between 2 and 7 percent of the population has OCPD, making it the most prevalent personality disorder. Those with existing mental health diagnoses are more likely to be diagnosed with OCPD. More research is needed to demonstrate the role that OCPD plays in these diagnoses. The symptoms of OCPD include: The most important thing you can do is recognize that the behavior that someone with OCPD exhibits is part of their personality, which is an enduring characteristic of the psychological makeup of that person. Healthline Medical Team Answers represent the opinions of our medical experts. All content is strictly informational and should not be considered medical advice.

Chapter 3 : Obsessive-Compulsive Disorder (OCD): Symptoms, Treatment, and Self-Help

Obsessive-compulsive disorder (OCD) is a mental disorder where people feel the need to check things repeatedly, perform certain routines repeatedly (called "rituals"), or have certain thoughts repeatedly (called "obsessions").

Regardless of the interrelationship of the two conditions, the comorbid occurrence of these two types of symptoms can cause a clinical dilemma because selective serotonin reuptake inhibitors SSRIs -which are quite commonly used to treat OCD-increases the risk of precipitating manic symptoms. In support of this hypothesis, a study using Positron Emission Tomography PET found that in untreated persons with BD the serotonin-transporter binding potential in the insular and dorsal cingulate cortex was higher among BD patients with pathological obsessions and compulsions than among BD patients without such symptoms. Compared to patients with BD without comorbid OCD, those that have comorbid BD and OCD often have a more severe form of BD, have more prolonged episodes, are less adherent to medication, and are less responsive to medication. The most commonly reported compulsions among patients with comorbid OCD and BD are compulsive sorting,[14 , 19 , 20 , 21] controlling or checking, [20] repeating behaviors,[13 , 22] excessive washing,[20] and counting. Compared to BD patients without OCD, a greater proportion of patients with both disorders had a lifetime history of suicidal ideation and suicide attempts. Clinicians should pay attention to its complex clinical manifestations and carefully consider the treatment principles outlined above. Biography Open in a separate window Dr. Peng obtained his Doctoral Degree in Medicine M. He is currently the vice director of the Mood Disorder Unit of the Shanghai Mental Health Center where he works as an attending physician. His main research interests are clinical and neuroimaging studies on mood disorders. Funding Statement There was no funding support provided for the preparation of this report. Footnotes Conflict of interest: The authors declare no confict of interest related to this manuscript. Psychiatric and medical comorbidities of bipolar disorder. Comorbidity for obsessive-compulsive disorder in bipolar and unipolar disorders. Pharmacotherapy of obsessive-compulsive disorder: Epub Nov 2. Vieta E, Bernardo M. Antidepressant-induced mania in obsessive-compulsive disorder. Mania associated with antidepressant treatment: Epub Dec 2. A study of co-occurrence of hierarchy-free syndromes. Clinical Psychiatry, 3rd ed. Elsevier Health Sciences; Serotonin transporter binding in bipolar disorder assessed using [11c] DASB and positron emission tomography. Bipolar and nonbipolarobsessive-compulsive disorder: Obsessive-compulsive syndromes and disorders: Eur Arch Psychiatry Clin Neurosci. Associationof polymorphisms in HCN4 with mood disorders and obsessive compulsive disorder. Bipolar obsessive compulsive disorder and personality disorders. Impact of obsessive-compulsive disorder comorbidity on the socio-demographic and clinical features of patients with bipolar disorder. Bipolar disorder and comorbid obsessive-compulsive disorder is associated with higher rates of anxiety and impulse control disorders. Course of psychiatric and substance abuse syndromes co-occurring with bipolar disorder after a first psychiatric hospitalization. Comparison of clinical characteristics in episodic and chronic obsessive-compulsive disorder. Clinical expression of obsessive compulsive disorder in women with bipolar disorder. The clinical impact of mood disorder comorbidity on obsessive compulsive disorder. Episodic course in obsessive compulsive disorder. Obsessive compulsive disorder with and without bipolar disorder. A naturalistic exploratory study of the impact of demographic, phenotypic and comorbid features in pediatric obsessive-compulsive disorder. Phenomenological features and clinical impact of affective disorders in OCD: Impact of comorbid anxiety disorders on outcome in a cohort of patients with bipolar disorder. Correlates and impact of obsessive-compulsive comorbidity in bipolar disorder. Anxiety disorder comorbidity in bipolar disorder patients: Co-morbid anxiety disorders in bipolar disorder and major depression: Epub Nov Practice guideline for the treatment of patients with bipolar disorder revision Am J Psychiatry. Practice guideline for the treatment of patients with obsessive-compulsive disorder. Successful treatment of comorbid obsessive compulsive disorder with aripiprazole in three patients with bipolar disorder.

Chapter 4 : Obsessive-Compulsive Disorder (OCD) | Anxiety and Depression Association of America, ADA

Obsessive-compulsive personality disorder (OCPD) is a personality disorder that's characterized by extreme perfectionism, order, and neatness. People with OCPD will also feel a severe need to.

Educational Tourette Syndrome TS often occurs with other related conditions also called co-occurring conditions. People with TS and related conditions can be at higher risk for learning, behavioral, and social problems. The symptoms of other disorders can complicate the diagnosis and treatment of TS and create extra challenges for people with TS and their families, educators, and health professionals. Among children with TS: They might act without thinking about what the result will be and, in some cases, they are also overly active. It is normal for children to have trouble focusing and behaving at one time or another. However, for children with ADHD. Obsessive-compulsive behaviors and obsessive-compulsive disorder OCD have been shown to occur among more than one-third of people with TS. ODD usually starts before a child is 8 years of age, but no later than early adolescence. Children with ODD might show symptoms most often with people they know well, such as family members or a regular care provider. Examples of ODD behaviors include: Getting angry or being resentful or vindictive often. Annoying others on purpose or easily becoming annoyed with others. They might have more injuries and difficulty with friends. It is important to get a diagnosis and treatment plan from a mental health professional as soon as possible. Effective treatments for disruptive behaviors include behavior therapy training for parents. Symptoms might include extreme verbal or physical aggression. Examples of verbal aggression include extreme yelling, screaming, and cursing. Examples of physical aggression include extreme shoving, kicking, hitting, biting, and throwing objects. Among people with TS, symptoms of rage are more likely to occur at home than outside the home. Treatment can include behavior therapy, learning how to relax, and social skills training. Some of these methods will help individuals and families better understand what can cause the symptoms of rage, how to avoid encouraging these behaviors, and how to use appropriate discipline for these behaviors. These include generalized anxiety disorder, OCD, panic disorder, post-traumatic stress disorder, separation anxiety, and different types of phobias. Separation anxiety is most common among young children. These children feel very worried when they are apart from their parents. However, if these feelings do not go away and they interfere with daily life for example, keeping a child home from school or other activities, or keeping an adult from working or attending social activities , a person might have depression. Having either a depressed mood or a loss of interest or pleasure for at least 2 weeks might mean that someone has depression. Children and teens with depression might be irritable instead of sad. To be diagnosed with depression, other symptoms also must be present, such as: Changes in eating habits or weight gain or loss. Changes in sleep habits. Changes in activity level others notice increased activity or that the person has slowed down. Feelings of worthlessness or guilt. Difficulty thinking, concentrating, or making decisions. Repeated thoughts of death. Thoughts or plans about suicide, or a suicide attempt. Depression can be treated with counseling and medication. Children with TS were also less likely to receive effective coordination of care or have a medical home, which means a primary care setting where a team of providers provides health care and preventive services. However, people with TS might be more likely to have learning differences, a learning disability, or a developmental delay that affects their ability to learn. Many people with TS have problems with writing, organizing, and paying attention. People with TS might have problems processing what they hear or see. Or, the person might have problems with their other senses such as how things feel, smell, taste, and movement that affects learning and behavior. Children with TS might have trouble with social skills that affect their ability to interact with others. As a result of these challenges, children with TS might need extra help in school. Many times, these concerns can be addressed with accommodations and behavioral interventions for example, help with social skills. Accommodations can include things such as providing a different testing location or extra testing time, providing tips on how to be more organized, giving the child less homework, or letting the child use a

computer to take notes in class. Children also might need behavioral interventions, therapy, or they may need to learn strategies to help with stress, paying attention, or other symptoms. For More Information CDC is working with the Tourette Association of America to provide information about TS and other concerns and conditions to health care providers, educators, and families, so that children with TS can get the best available treatment and support. To learn more about other concerns and conditions related to TS, please visit the Tourette Association website. A National Profile of Tourette Syndrome, J Dev Behav Pediatr 35 5 , Centers for Disease Control and Prevention. Prevalence of diagnosed Tourette Syndrome in persons aged years â€" United States, Gilles de la Tourette Syndrome: An international perspective on Tourette Syndrome: Selected findings from individuals in 22 countries. Devel Med Child Neurol. Clinical analysis of Gilles de la Tourette Syndrome based on cases.

Chapter 5 : Signs and Symptoms of Obsessive-Compulsive Disorder

Obsessive-compulsive personality disorder is characterized by a preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and.

When rules and established procedures do not dictate the correct answer, decision making may become a time-consuming, often painful process. Individuals with obsessive-compulsive personality disorder may have such difficulty deciding which tasks take priority or what is the best way of doing some particular task that they may never get started on anything. They are prone to become upset or angry in situations in which they are not able to maintain control of their physical or interpersonal environment, although the anger is typically not expressed directly. For example, a person may be angry when service in a restaurant is poor, but instead of complaining to the management, the individual ruminates about how much to leave as a tip. On other occasions, anger may be expressed with righteous indignation over a seemingly minor matter. People with this disorder may be especially attentive to their relative status in dominance-submission relationships and may display excessive deference to an authority they respect and excessive resistance to authority that they do not respect. Individuals with this disorder usually express affection in a highly-controlled or stilted fashion and may be very uncomfortable in the presence of others who are emotionally expressive. Their everyday relationships have a formal and serious quality, and they may be stiff in situations in which others would smile and be happy e. They carefully hold themselves back until they are sure that whatever they say will be perfect. They may be preoccupied with logic and intellect. The pattern is seen in two or more of the following areas: The enduring pattern is inflexible and pervasive across a broad range of personal and social situations. It typically leads to significant distress or impairment in social, work, or other areas of functioning. The pattern is stable and of long duration, and its onset can be traced back to early adulthood or adolescence. Symptoms of Obsessive-Compulsive Personality Disorder A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four or more of the following: It is uncommon for them to be diagnosed in childhood or adolescence, because a child or teen is under constant development, personality changes, and maturation. However, if it is diagnosed in a child or teen, the features must have been present for at least 1 year. Obsessive-compulsive personality disorder is approximately twice as prevalent in males than females, and occurs in between 2. Like most personality disorders, obsessive-compulsive personality disorder typically will decrease in intensity with age, with many people experiencing few of the most extreme symptoms by the time they are in their 40s or 50s. Personality disorders such as obsessive-compulsive personality disorder are typically diagnosed by a trained mental health professional, such as a psychologist or psychiatrist. Family physicians and general practitioners are generally not trained or well-equipped to make this type of psychological diagnosis. So while you can initially consult a family physician about this problem, they should refer you to a mental health professional for diagnosis and treatment. A diagnosis for obsessive-compulsive personality disorder is made by a mental health professional comparing your symptoms and life history with those listed here. They will make a determination whether your symptoms meet the criteria necessary for a personality disorder diagnosis. This suggests that no single factor is responsible â€" rather, it is the complex and likely intertwined nature of all three factors that are important. Medications may also be prescribed to help with specific troubling and debilitating symptoms. He has been writing about psychology and mental health issues since Obsessive Compulsive Personality Disorder. Retrieved on November 6, , from https:

Chapter 6 : Obsessiveâ€“compulsive disorder - Wikipedia

Obsessive-Compulsive Disorder Symptoms, Causes and Effects Obsessive-compulsive disorder, or OCD, is an anxiety disorder that generally causes extreme discomfort. Sufferers are often riddled with persistent and recurrent impulses, thoughts and images that are unwanted.

Certain groups of symptoms usually occur together. These groups are sometimes viewed as dimensions or clusters that may reflect an underlying process. These symptoms fit into three to five groupings. The observed groups included a "symmetry factor", a "forbidden thoughts factor", a "cleaning factor", and a "hoarding factor". The "symmetry factor" correlated highly with obsessions related to ordering, counting, and symmetry, as well as repeating compulsions. The "forbidden thoughts factor" correlated highly with intrusive and distressing thoughts of a violent, religious, or sexual nature. The "cleaning factor" correlated highly with obsessions about contamination and compulsions related to cleaning. The "hoarding factor" only involved hoarding related obsessions and compulsions, and was identified as being distinct from other symptom groupings. Furthermore, some subtypes have been associated with improvement in performance on certain tasks such as pattern recognition washing subtype and spatial working memory obsessive thought subtype. Subgroups have also been distinguished by neuroimaging findings and treatment response. Neuroimaging studies on this have been too few, and the subtypes examined have differed too much to draw any conclusions. On the other hand, subtype dependent treatment response has been studied, and the hoarding subtype has consistently responded least to treatment. Primarily obsessional obsessive compulsive disorder People with OCD may face intrusive thoughts, such as thoughts about the Devil shown is a painted interpretation of Hell Obsessions are thoughts that recur and persist, despite efforts to ignore or confront them. Within and among individuals, the initial obsessions, or intrusive thoughts, vary in their clarity and vividness. A relatively vague obsession could involve a general sense of disarray or tension accompanied by a belief that life cannot proceed as normal while the imbalance remains. A more intense obsession could be a preoccupation with the thought or image of someone close to them dying [14] [15] or intrusions related to " relationship rightness ". Other individuals with OCD may experience the sensation of invisible protrusions emanating from their bodies, or have the feeling that inanimate objects are ensouled. For example, obsessive fears about sexual orientation can appear to the person with OCD, and even to those around them, as a crisis of sexual identity. For example, an individual who engages in compulsive hoarding might be inclined to treat inorganic matter as if it had the sentience or rights of living organisms, while accepting that such behavior is irrational on a more intellectual level. There is a debate as to whether or not hoarding should be considered with other OCD symptoms. OCD without overt compulsions could, by one estimate, characterize as many as 50 percent to 60 percent of OCD cases. The person might feel that these actions somehow either will prevent a dreaded event from occurring or will push the event from their thoughts. Excessive skin picking , hair-pulling , nail biting , and other body-focused repetitive behavior disorders are all on the obsessiveâ€”compulsive spectrum. Some people use compulsions to avoid situations that may trigger their obsessions. Although some people do certain things over and over again, they do not necessarily perform these actions compulsively. For example, bedtime routines, learning a new skill, and religious practices are not compulsions. Whether or not behaviors are compulsions or mere habit depends on the context in which the behaviors are performed. For example, arranging and ordering DVDs for eight hours a day would be expected of one who works in a video store, but would seem abnormal in other situations. In such situations, it can be hard for the person to fulfil their work, family, or social roles. In some cases, these behaviors can also cause adverse physical symptoms. For example, people who obsessively wash their hands with antibacterial soap and hot water can make their skin red and raw with dermatitis. For example, a person compulsively checking the front door may argue that the time taken and stress caused by one more check of the front door is much less than the time and stress associated with being robbed, and thus checking is the better option. In practice, after that check, the person is still not sure and

deems it is still better to perform one more check, and this reasoning can continue as long as necessary. Good or fair insight is characterized by the acknowledgment that obsessive-compulsive beliefs are or may not be true. Poor insight is characterized by the belief that obsessive-complsive beliefs are probably true. In such cases, the person with OCD will truly be uncertain whether the fears that cause them to perform their compulsions are irrational or not. After some discussion, it is possible to convince the individual that their fears may be unfounded. It may be more difficult to do ERP therapy on such people because they may be unwilling to cooperate, at least initially. There are severe cases in which the person has an unshakeable belief in the context of OCD that is difficult to differentiate from psychotic disorders. Risk factors include a history of child abuse or other stress -inducing event. In cases where OCD develops during childhood, there is a much stronger familial link in the disorder than cases in which OCD develops later in adulthood. Examples would be moderate constant checking of hygiene, the hearth or the environment for enemies. Similarly, hoarding may have had evolutionary advantages. In this view OCD may be the extreme statistical "tail" of such behaviors, possibly due to a high amount of predisposing genes. Functional neuroimaging during symptom provocation has observed abnormal activity in the orbitofrontal cortex , left dorsolateral prefrontal cortex , right premotor cortex , left superior temporal gyrus , globus pallidus externus , hippocampus and right uncus. Weaker foci of abnormal activity were found in the left caudate , posterior cingulate cortex and superior parietal lobule. Affective tasks were observed to relate to increased activation in the precuneus and posterior cingulate cortex PCC , while decreased activation was found in the pallidum, ventral anterior thalamus and postetior caudate. Observed similarities include dysfunction of the anterior cingulate cortex , and prefrontal cortex , as well as shared deficits in executive functions. The first category of executive dysfunction is based on the observed structural and functional abnormalities in the dlPFC, striatum, and thalamus. Symptom specific neuroimaging abnormalities include the hyperactivity of caudate and ACC in checking rituals, while finding increased activity of cortical and cerebellar regions in contamination related symptoms. This is supported by the observation that those with OCD demonstrate decreased activation of the ventral striatum when anticipating monetary reward, as well as increase functional connectivity between the VS and the OFC. Furthermore, those with OCD demonstrate reduced performance in pavlovian fear extinction tasks, hyper responsiveness in the amygdala to fearful stimuli, and hypo-resonsiveness in the amygdala when exposed to positively valanced stimuli. Stimulation of the nucleus accumbens has also been observed to effectively alleviate both obsessions and compulsions, supporting the role of affective dysregulation in generating both. Studies of peripheral markers of serotonin, as well as challenges with proserotonergic compounds have yielded inconsistent results, including evidence pointing towards basal hyperactivity of serotonergic systems. Despite inconsistencies in the types of abnormalities found, evidence points towards dysfunction of serotonergic systems in OCD. Although antipsychotics, which act by antagonizing dopamine receptors may improve some cases of OCD, they frequently exacerbate others. Antipsychotics, in the low doses used to treat OCD, may actually increased the release of dopamine in the prefrontal cortex, through inhibiting autoreceptors. Further complicating things is the efficacy of amphetamines, decreased dopamine transporter activity observed in OCD, [69] and low levels of D2 binding in the striatum. Findings such as increased cerebrospinal glutamate, less consistent abnormalities observed in neuroimaging studies, and the efficacy of some glutaminergic drugs such as riluzole have implicated glutamate in OCD. The Quick Reference to the edition of the DSM states that several features characterize clinically significant obsessions and compulsions. Such obsessions, the DSM says, are recurrent and persistent thoughts, impulses or images that are experienced as intrusive and that cause marked anxiety or distress. These thoughts, impulses or images are of a degree or type that lies outside the normal range of worries about conventional problems. Compulsions become clinically significant when a person feels driven to perform them in response to an obsession, or according to rules that must be applied rigidly, and when the person consequently feels or causes significant distress. Therefore, while many people who do not suffer from OCD may perform actions often associated with OCD such as ordering items in a pantry by height , the distinction with clinically significant OCD lies in the fact that the person who suffers from OCD must perform

these actions, otherwise they will experience significant psychological distress. These behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these activities are not logically or practically connected to the issue, or they are excessive. In addition, at some point during the course of the disorder, the individual must realize that their obsessions or compulsions are unreasonable or excessive. Moreover, the obsessions or compulsions must be time-consuming taking up more than one hour per day or cause impairment in social, occupational or scholastic functioning. With measurements like these, psychiatric consultation can be more appropriately determined because it has been standardized. As a result, people with OCD are often aware that their behavior is not rational, are unhappy about their obsessions but nevertheless feel compelled by them. At first, for example, someone might touch something only very mildly "contaminated" such as a tissue that has been touched by another tissue that has been touched by the end of a toothpick that has touched a book that came from a "contaminated" location, such as a school. That is the "exposure". The "ritual prevention" is not washing. Another example might be leaving the house and checking the lock only once exposure without going back and checking again ritual prevention. The person fairly quickly habituates to the anxiety-producing situation and discovers that their anxiety level drops considerably; they can then progress to touching something more "contaminated" or not checking the lock at allâ€”again, without performing the ritual behavior of washing or checking. Medication A blister pack of clomipramine under the brand name Anafranil The medications most frequently used are the selective serotonin reuptake inhibitors SSRIs. In children, SSRIs can be considered as a second line therapy in those with moderate-to-severe impairment, with close monitoring for psychiatric adverse effects. Quetiapine is no better than placebo with regard to primary outcomes, but small effects were found in terms of YBOCS score. The efficacy of quetiapine and olanzapine are limited by the insufficient number of studies. None of the atypical antipsychotics appear to be useful when used alone. In this procedure, a surgical lesion is made in an area of the brain the cingulate cortex. In the United States, the Food and Drug Administration approved deep-brain stimulation for the treatment of OCD under a humanitarian device exemption requiring that the procedure be performed only in a hospital with specialist qualifications to do so. Children Therapeutic treatment may be effective in reducing ritual behaviors of OCD for children and adolescents. In a recent meta-analysis of evidenced-based treatment of OCD in children, family-focused individual CBT was labeled as "probably efficacious", establishing it as one of the leading psychosocial treatments for youth with OCD.

Chapter 7 : Obsessive Compulsive Personality Disorder

Obsessive-compulsive disorder is a type of mental illness. People with OCD can have either obsessive thoughts and urges or compulsive, repetitive behaviors. Some have both obsessions and compulsions.

Obsessions are the worrisome thoughts that cause anxiety. Compulsions are the behaviors you use to relieve that anxiety. It tends to begin slowly and become more intense as you mature. In severe cases, it has a profound impact on quality of life. Without treatment, it can become quite disabling. Some common obsessions associated with OCD include: Performing a ritual like having to touch something a certain number of times or take a particular number of steps focusing on positive thoughts to combat the bad thoughts Social Signs: For others, social situations trigger compulsions. Some things you might notice in a person with OCD: A child who is compelled to count, for instance, may not be able to complete the ritual. The stress can cause angry outbursts and other misbehaviors. One who is afraid of germs may be fearful of playing with other children. A child with OCD may fear they are crazy. Obsessions and compulsions can interfere with schoolwork and lead to poor academic performance. Children with OCD may have trouble expressing themselves. They may be inflexible and upset when plans change. Their discomfort in social situations can make it difficult to make friends and maintain friendships. In an attempt to mask their compulsions, children with OCD may withdraw socially. Isolation increases the risk for depression. It seems to run in families, but there may be environmental factors involved. Most of the time, symptoms of OCD occur before age Treatment usually involves psychotherapy, behavioral modification therapy, or psychiatric medications, alone or in combination. According to Harvard Medical School , with treatment, approximately 10 percent of patients fully recover and about half of patients show some improvement.

Chapter 8 : Obsessiveâ€“compulsive personality disorder - Wikipedia

Obsessive-compulsive disorder (OCD) is a clinical syndrome whose hallmarks are excessive, anxiety-evoking thoughts and compulsive behaviors that are generally recognized as unreasonable, but which cause significant distress and impairment.

Miguel Find articles by Euripedes C. This article has been cited by other articles in PMC. Abstract Obsessive-compulsive disorder OCD is a clinical syndrome whose hallmarks are excessive, anxiety-evoking thoughts and compulsive behaviors that are generally recognized as unreasonable, but which cause significant distress and impairment. When these are the exclusive symptoms, they constitute uncomplicated OCD. OCD may also occur in the context of other neuropsychiatric disorders, most commonly other anxiety and mood disorders. The question remains as to whether these combinations of disorders should be regarded as independent, cooccurring disorders or as different manifestations of an incompletely understood constellation of OCD spectrum disorders with a common etiology. Additional considerations are given here to two potential etiology-based subgroups: Considering the status of current research, the concept of OCD and OCD-related spectrum conditions seems fluid in , and in need of ongoing reappraisal. Obsessive-compulsive disorder OCD occurs worldwide, with common features across diverse ethnic groups and cultures. Moreover, a number of other psychiatric and neurologic disorders have similar phenomenological features, can be comorbid with OCD, or are sometimes even conceptualized as uncommon presentations of OCD. Ruminative, obsessional, preoccupying mental agonies coupled with perseverative, ritualized compulsionresembling behaviors have been depicted in biblical documents as well as Greek and Shakespearian tragedies. In modern nosology, a number of different approaches have been suggested to characterize this syndrome, yet the question of how best to categorize OCD subgroups remains under debate in There have, however, been questions raised about this categorization on the basis of some phenomenological differences between OCD and the other anxiety disorders. As such, suggestions have been made that, in the forthcoming DSM-5, OCD should be removed from its position as one of the six anxiety disorders - a reformulation still under debate. One solution under discussion is that OCD should constitute an independent entity in DSM-5 ie, remain outside of any larger grouping , congruent with its designation as such in the current international diagnostic manual, ICD International Statistical Classification of Diseases and Related Health Problems. The concept of an OCSD classification was first postulated over a decade ago. However, the concept of a compulsive-impulsive continuum has not been widely subscribed to in either a recent survey of OCD experts or in recent reviews. It does not reiterate already well-evaluated aspects of OCD spectrum concepts recently published in expert reviews eg, refs 12, Rather, it discusses new data primarily from recent epidemiologic and clinical research, as well as new quantitative psychological, physiological, and genetic studies with the aim of reappraising and developing additional elements related to the OCSDs and OCRDs. Particular points of emphasis are questions regarding i what OCD phenotypes might be of value in present and future genetic studies; and ii other types of etiological contributions to OCRDs, with, of course, the ultimate aim of better treatments for OCRDs that might be based on more than our current descriptive nosologies. Our immediate hope in this review is to spur additional thoughts as the field moves towards clarifying how OCD-related disorders might arise and manifest at the phenomenological and mechanistic levels. It is listed within the Anxiety Disorder section. The text highlights that if an individual attempts to resist or delay a compulsion, they can experience marked increases in anxiety and distress that are relieved by the rituals. OCD symptom heterogeneity in individuals While the core components of OCD anxiety-evoking obsessions and repetitive compulsions are recognizable as the cardinal features of OCD, the specific content of these symptoms varies widely. Thus, there is clear evidence that within OCD, there is symptom heterogeneity. There also exists an inseparable overlapping of symptom groupings blue components , such that despite separable conceptual entities, there is an overall merging of these groupings on a more hierarchical level.

Chapter 9 : CBT Therapy for OBSESSIVE COMPULSIVE Disorder, OCD, ABCT

If you have obsessive-compulsive disorder (OCD), you may have compulsions in which you repeat behaviors over and over again. For instance, you might have to repeatedly check to make sure that the front door is locked or that the stove is turned off.

The repeated cleaning of one or more items Repeatedly washing your hands Constantly checking the stove or door locks Arranging items to face a certain way Emotional Symptoms of Obsessive-Compulsive Disorder Sufferers of OCD are generally very anxious and emotional. They display many non-OCD symptoms, such as signs of depression , excessive worry, extreme tension, and the constant feeling that nothing is ever right. Physical Symptoms of Obsessive-Compulsive Disorder Aside from the obvious compulsive behaviors a person with OCD displays, there are no physical signs of this disorder; however, a person with OCD can develop physical problems. For example, a person with a germ obsession may wash their hands so much that the skin on them becomes red, raw and painful. Short-Term and Long-Term Effects of OCD A person with OCD may experience multiple short-term effects, including the inability to function as a contributing member of society, difficulties at school or work, or trouble maintaining friendships or romantic relationships. The long-term effects of OCD generally develop due to the poor quality of life that most extreme sufferers have. Long-term effects include depression, constant anxiety and an increased risk of substance abuse. It is best to get on the path to recovery as soon as possible to prevent the worsening of these effects. Give us a call on our hotline today at. If your loved ones have told you that you have obsessive thoughts or are compulsive in action, you have likely noticed that you do, in fact, have some compulsive behaviors. Most patients with OCD are aware of the behaviors they are displaying; they just cannot stop them. There is no self-assessment exam for OCD sufferers, but you can self-assess by getting together with your loved ones and coming up with a list of behaviors you consistently display. You can then discuss this list with your healthcare provider. After speaking to you about your thoughts and behaviors, your doctor may recommend a psychological evaluation. Your doctor may also want to speak to your loved ones and close friends. Anti-Anxiety Drug Options The medications used to treat obsessive-compulsive disorder are the same drugs used to treat most anxiety disorders. Psychotherapy is another important aspect of treatment and generally recommended in conjunction with medication use. These psychiatric medicines can control compulsions and obsessive thoughts. They work by increasing the level of serotonin in your brain, which is generally low in sufferers of OCD. Medication Side Effects Most anxiety medications, including the ones listed above, have side effects. Vomiting, diarrhea, loss of coordination, shaking, abnormal urination, vision changes, extreme confusion, stiff muscles, appetite changes, loss of sex drive and more are all possible side effects of these medications. If you experience any of these symptoms, call your doctor right away. If you start to experience these symptoms, contact a medical provider or call right away. Depression and Obsessive-Compulsive Disorder Depression often occurs with OCD, which is why part of the treatment plan involves psychotherapy. Most of the anti-anxiety medications used to treat OCD are suitable for treating depression as well. Your doctor might also prescribe a separate set of antidepressants to take with your OCD medications depending on your particular situation. These conditions differ in every individual with OCD because the behavior each sufferer displays is different. For example, if you are obsessed with the thought of being thin, you may develop anorexia or bulimia, and your doctor may diagnose you with both OCD and one of these ailments. Treatment on OCD should focus on both issues in order to be successful. Getting help will allow you or your loved one to dramatically improve the quality of life you live. People with OCD are driven by unreasonable thoughts and unwarranted fears, referred to as "obsessions," to perform repetitive behaviors, referred to as "compulsions. The repetitions must ultimately be reinstated to alleviate mounting stressful feelings and anxiety. Learn more about what this means here. Our helpline is offered at no cost to you and with no obligation to enter into treatment.