

Obsessive Compulsive and Related Disorders

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OBSESSIVE COMPULSIVE DISORDER AND RELATED DISORDERS

OCD

(OCD) is characterized by recurrent, persistent, unwanted, and intrusive thoughts, urges, or images (obsessions) and/or by repetitive behaviours or mental acts that patients feel driven to do (compulsions) to try to lessen or prevent the anxiety that obsessions cause.

Diagnostic criteria

A) Presence of obsessions, compulsions or both:

Obsession

Obsessions are unwanted, intrusive thoughts, urges, or images, the presence of which usually cause marked distress or anxiety. The dominant theme of the obsessive thoughts may be harm, risk to self or others, danger, contamination, doubt, loss, or aggression.

Examples

For example, patients may obsess about becoming contaminated with dirt or germs unless they wash their hands for > 2 h a day. The obsessions are not pleasurable. Thus, patients try to ignore and/or suppress the thoughts, urges, or images. Or they try to neutralize them by performing a compulsion.

Compulsion

Compulsions (often called rituals) are excessive, repetitive, purposeful behaviours that affected people feel they must do to prevent or reduce the anxiety caused by their obsessive thoughts or to neutralize their obsessions.

Examples

- Washing (e.g. hand washing, showering) Checking (e.g., that the stove is turned off, that doors are locked)

- Counting (e.g. repeating a behaviour a certain number of times)
- Ordering (e.g. arranging tableware or workspace items in a specific pattern)
- B) The obsessions or compulsions are time-consuming (e.g., take more than one 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 abuse, a medication or another medical condition).
- D) The disturbance is not better explained by the symptoms of another mental 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.

Causes of OCD

The causes of OCD are not fully understood. There are several theories about the causes of OCD, including:

- Compulsions are learned behaviours, which become repetitive and habitual when they are associated with relief from anxiety.
- OCD is due to genetic and hereditary factors.
- Chemical, structural and functional abnormalities in the brain are the cause.
- Distorted beliefs reinforce and maintain symptoms associated with OCD.

It is possible that several factors interact to trigger the development of OCD.

Genetic causes

OCD runs in families and can be considered a "familial disorder." The disease may span generations with close relatives of people with OCD significantly more likely to develop OCD themselves.

Autoimmune causes

Some rapid-onset cases of OCD in children might be consequences of Group A streptococcal infections, which cause inflammation and dysfunction in the basal ganglia. These cases are grouped and referred to as paediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS).

Behavioural causes

The behavioural theory suggests that people with OCD associate certain objects or situations with fear. They learn to avoid those things or learn to perform "rituals" to help reduce the fear. This fear and avoidance or ritual cycle may begin during a period of intense stress, such as when starting a new job or just after an important relationship comes to an end.

Cognitive causes

The behavioural theory outlined above focuses on how people with OCD make an association between an object and fear. The cognitive theory, however, focuses on how people with OCD misinterpret their thoughts. Most people have unwelcome or intrusive thoughts at certain times, but for individuals with OCD, the importance of those thoughts are exaggerated.

Neurological causes

Imbalances in the brain chemicals serotonin and glutamate may play a part in OCD.

Environmental causes

Environmental stressors may be a trigger for OCD in people with a tendency toward developing the condition. Traumatic brain injury (TBI) in adolescents and children has also been associated with an increased risk of onset of obsessive compulsions.

Treatment

- Exposure and ritual prevention therapy
- SSRI or clomipramine

Exposure and ritual prevention therapy

Exposure and ritual prevention therapy is often effective in patients with obsessive-compulsive disorder; its essential element is gradually exposing patients to situations or people that trigger the anxiety-provoking obsessions and rituals while asking them not to perform their rituals.

Example

A patient with contamination obsessions and washing compulsions may be asked to touch a toilet seat without washing her hands.

This approach allows the anxiety triggered by exposure to diminish through habituation. Improvement often continues for years, especially in patients who master the approach and use it even after formal treatment has ended. However, some patients have incomplete responses (as some also do to drugs).

SSRI

SSRIs and clomipramine (a tricyclic antidepressant with potent serotonergic effects), are often very effective. Patients often require higher doses than are typically needed for depression and most anxiety disorders. Many experts believe that combining exposure and ritual prevention with drug therapy is best, especially for severe cases.

There are a number of drugs available for treating OCD, with the development of SSRIs expanding the range of treatment options. SSRIs that may be prescribed to help people manage OCD include:

- clomipramine
- fluoxetine
- fluvoxamine
- paroxetine hydrochloride
- sertraline
- citalopram
- escitalopram

SSRIs are generally used in higher doses for OCD than for depression. It might take up to 3 months for results to be noticed.

BODY DISMORPHIC DISORDER

Overview

Body dysmorphic disorder is a mental health disorder in which you can't stop thinking about one or more perceived defects or flaws in your appearance — a flaw that appears minor or can't be seen by others. But you may feel so embarrassed, ashamed and anxious that you may avoid many social situations.

Diagnostic criteria

Signs and symptoms of body dysmorphic disorder include:

- Being extremely preoccupied with a perceived flaw in appearance that to others can't be seen or appears minor
- Strong belief that you have a defect in your appearance that makes you ugly or deformed
- Belief that others take special notice of your appearance in a negative way or mock you
- Engaging in behaviours aimed at fixing or hiding the perceived flaw that are difficult to resist or control, such as frequently checking the mirror, grooming or skin picking
- Attempting to hide perceived flaws with styling, makeup or clothes
- Constantly comparing your appearance with others
- Frequently seeking reassurance about your appearance from others
- Having perfectionist tendencies
- Seeking cosmetic procedures with little satisfaction
- Avoiding social situations

Causes

As with most mental disorders, BDD's cause is likely intricate, altogether biopsychosocial, through an interaction of multiple factors, including genetic, physical (e.g. disabilities), developmental, psychological, social, and cultural. BDD usually develops during early adolescence, although many patients note earlier trauma, abuse, neglect, teasing, or bullying. In many cases, social anxiety earlier in life precedes the development of BDD. Family influence has also been linked to the development of BDD.

Treatment

Treatment for body dysmorphic disorder often includes a combination of cognitive behavioural therapy and medications.

Cognitive behavioural therapy

Cognitive behavioural therapy for body dysmorphic disorder focuses on:

- Helping you learn how negative thoughts, emotional reactions and behaviours maintain problems over time
- Challenging automatic negative thoughts about your body image and learning more-flexible ways of thinking

- Learning alternate ways to handle urges or rituals to help reduce mirror checking or reassurance seeking
- Teaching you other behaviours to improve your mental health, such as addressing social avoidance

Medications

Although there are no medications specifically approved by the Food and Drug Administration (FDA) to treat body dysmorphic disorder, medications used to treat other mental health conditions — such as depression and obsessive-compulsive disorder — can be effective.

- **Selective serotonin reuptake inhibitors (SSRIs).** Because body dysmorphic disorder is thought to be caused in part by problems related to the brain chemical serotonin, SSRIs may be prescribed. SSRIs appear to be more effective for body dysmorphic disorder than other antidepressants and may help control your negative thoughts and repetitive behaviours.
- **Other medications.** In some cases, you may benefit from taking other medications in addition to an SSRI, depending on your symptoms.

HOARDING DISORDER

Overview

Hoarding disorder is a persistent difficulty discarding or parting with possessions because of a perceived need to save them. A person with hoarding disorder experiences distress at the thought of getting rid of the items. Excessive accumulation of items, regardless of actual value, occurs.

Symptoms

Getting and saving an excessive number of items, gradual build-up of clutter in living spaces and difficulty discarding things are usually the first signs and symptoms of hoarding disorder, which often surfaces during the teenage to early adult years.

As the person grows older, he or she typically starts acquiring things for which there is no immediate need or space. By middle age, symptoms are often severe and may be harder to treat.

Problems with hoarding gradually develop over time and tend to be a private behaviour. Often, significant clutter has developed by the time it reaches the attention of others.

Signs and symptoms may include:

- Excessively acquiring items that are not needed or for which there's no space
- Persistent difficulty throwing out or parting with your things, regardless of actual value
- Feeling a need to save these items, and being upset by the thought of discarding them
- Building up of clutter to the point where rooms become unusable
- Having a tendency toward indecisiveness, perfectionism, avoidance, procrastination, and problems with planning and organizing

Excessive acquiring and refusing to discard items results in:

- Disorganized piles or stacks of items, such as newspapers, clothes, paperwork, books or sentimental items
- Possessions that crowd and clutter your walking spaces and living areas and make the space unusable for the intended purpose, such as not being able to cook in the kitchen or use the bathroom to bath.
- Build-up of food or trash to unusually excessive, unsanitary levels
- Significant distress or problems functioning or keeping yourself and others safe in your home
- Conflict with others who try to reduce or remove clutter from your home
- Difficulty organizing items, sometimes losing important items in the clutter

People with hoarding disorder typically save items because:

- They believe these items are unique or will be needed at some point in the future
- The items have important emotional significance — serving as a reminder of happier times or representing beloved people or pets
- They feel safer when surrounded by the things they save
- They don't want to waste anything

Causes

The cause of hoarding disorder is unknown. Doctors have identified several risk factors associated with the condition. They include:

- Having a relative with the disorder
- Brain injury that triggers the need to save things

- Traumatic life events
- Mental disorders such as depression or obsessive-compulsive disorder
- Uncontrollable buying habits
- Inability to pass up free items such as coupons and flyers

Treatment

Treatment includes following:

Medication

Although no medication has received FDA approval for the treatment of compulsive hoarding, some monoamine reuptake inhibitors (venlafaxine, paroxetine) have been moderately successful in a small number of low-quality clinical studies. In patients where compulsive hoarding is secondary to or comorbid with frank OCD, serotonergic antidepressants such as SSRIs or the tricyclic antidepressant clomipramine are indicated, although the presence of hoarding predicts relatively poor treatment response. When examined, concurrent pharmacological and psychotherapeutic treatment appeared more effective than either alone.

Counselling

(CBT) is a commonly implemented therapeutic intervention for compulsive hoarding. As part of cognitive behaviour therapy, the therapist may help the patient to:

- Discover why he or she is compelled to hoard.
- Learn to organize possessions in order to decide what to discard.
- Develop decision-making skills.
- Declutter the home during in-home visits by a therapist or professional organizers.
- Gain and perform relaxation skills.
- Attend family and/or group therapy.
- Be open to trying psychiatric hospitalization if the hoarding is serious.
- Have periodic visits and consultations to keep a healthy lifestyle.

TRICHOTILLOMANIA

(Hair pulling disorder)

Overview

Trichotillomania also referred to as “hair-pulling disorder,” is a mental disorder classified under Obsessive-Compulsive and Related Disorders and involves recurrent, irresistible urges to pull hair from the scalp, eyebrows, eyelids, and other areas of the body, despite repeated attempts to stop or decrease hair pulling.

Diagnostic criteria

Other symptoms can include the following:

- Repeated attempts to decrease or stop hair pulling
- Hair pulling causes distress or impairment in social, occupational, or other areas of functioning
- An increasing feeling of tension before the hair pulling, or when trying to resist pulling
- A feeling of relief after pulling
- Noticeable hair loss
- Playing with pulled hair, or rubbing it across the face or skin
- Biting, chewing, or eating pulled hair
- Pulling certain kinds of hair (certain textures)
- Hair pulling often occurs in private

Causes

The cause of trichotillomania is unclear. But like many complex disorders, trichotillomania probably results from a combination of genetic and environmental factors.

Risk factors

These factors tend to increase the risk of trichotillomania:

- **Family history.** Genetics may play a role in the development of trichotillomania, and the disorder may occur in those who have a close relative with the disorder.
- **Age.** Trichotillomania usually develops just before or during the early teens — most often between the ages of 10 and 13 years — and it's often a lifelong problem. Infants also can be prone to hair pulling, but this is usually mild and goes away on its own without treatment.
- **Other disorders.** People who have trichotillomania may also have other disorders, such as depression, anxiety or obsessive-compulsive disorder (OCD).
- **Stress.** Severely stressful situations or events may trigger trichotillomania in some people.

Treatment of Trichotillomania

Treatment of trichotillomania can be complicated, and most treatment options require time and practice

- **Habit reversal:** This is often the primary treatment of trichotillomania. Individuals learn how to recognize situations where they are likely to pull hair and substitute other behaviours instead. Many people use journaling, alerts, and other strategies to increase awareness of triggers. Instead of pulling hair, a person might substitute behaviours such as; clenching fists or snapping an elastic band on the wrist.
- **Cognitive therapy:** This type of therapy can help people explore distorted beliefs related to hair pulling.
- **Self-awareness training:** Individuals learn to become more aware of their hair pulling patterns by tracking when they pull and detailing emotions and other important information.
- **Relaxation training:** This helps people learn to focus on and calm their central nervous systems in response to stress triggers.
- **Deep breathing training:** Learning the proper way to engage in deep breathing helps increase relaxation and focus.
- **Process-oriented therapy:** Talk therapy can be effective in helping people explore their triggers and emotions beneath the pulling.
- **Medication:** While there are no medications specific to the treatment of trichotillomania, SSRIs and SNRIs can be used to treat some of the accompanying symptoms of anxiety.

- **Family therapy:** For children and adolescents, family therapy helps parents learn to better respond to and manage symptoms.
- **Group therapy:** Trichotillomania can feel isolating. Group's help people connect with others enduring a similar struggle and provide support for one another.

EXCORIATION (SKIN PICKING) DISORDER

Overview

Excoriation disorder (also referred to as chronic skin-picking or dermatillomania) is a mental illness related to obsessive-compulsive disorder. It is characterized by repeated picking at one's own skin which results in skin lesions and causes significant disruption in one's life.

Diagnostic criteria

To be diagnosed with excoriation disorder, a person must show the following signs and symptoms

- Recurrent skin picking that results in skin lesions
- Repeated attempts to stop the behaviour
- The symptoms cause clinically significant distress or impairment
- The symptoms are not caused by a substance or medical, or dermatological condition
- The symptoms are not better explained by another psychiatric disorder

Etiology:

Skin picking disorder happens in both children and adults. It can begin at almost any age.

Skin picking disorder often develops in one of two ways:

- 1) After some kind of rash, skin infection, or small injury. You may pick at the scab or rash, which causes more injury to the skin and keeps the wound from healing. More itching leads to more picking and more scabbing, and the cycle continues.
 - 2) During a time of stress.
- You may absently pick at a scab or the skin around your nails and find that the repetitive action helps to relieve stress. It then becomes a habit.

- Skin picking disorder is considered a type of repetitive "self-grooming" behaviour called "Body-Focused Repetitive Behaviour" (BFRB).
- Other types of BFRBs include pulling or picking of the hair or nails that damages the body.

Treatment

Evidence suggests that both medication and cognitive- behavioural therapy (CBT) may effectively reduce symptoms of excoriation disorder.

Medication:

Successful treatment may include the use of selective serotonin reuptake inhibitors (SSRIs), which are antidepressants that also help reduce obsessive thoughts and compulsive behaviours.

Cognitive-behavioural therapy (CBT):

Cognitive- behavioural therapy helps individuals understand how their thoughts and behaviour patterns are related in order to reduce repetitive behaviours. Individuals learn how to change their thoughts so they can avoid picking at their skin.

SUBSTANCE/MEDICATION-INDUCED OBSESSIVE COMPULSIVE AND RELATED DISORDERS

Overview

Substance or medication-induced OCD occurs as a direct result of using drugs, such as prescribed medications, illicit substances, alcohol, or exposure to certain toxins. Medications or substances may induce obsessive-compulsive disorder symptoms and behaviours while under their influence or upon withdrawal from their use.

Symptoms:

The symptoms of substance or medication-induced OCD are similar to those of pure OCD. According to the DSM-V, a diagnosis is given only when OCD symptoms reach levels beyond

what is expected during drug use or toxin exposure and withdrawal. The symptoms and criteria considered when making a diagnosis for substance or medication-induced OCD include:

- Severe, intrusive obsessive thoughts and/or compulsive behaviours (i.e. obsessive checking, hand washing, skin picking, hair pulling, repetitive rituals)
- Symptoms begin within one month of drug or medication use, or upon withdrawal from a substance or medication known to cause OCD anxiety symptoms
- Symptoms are not due to a pre-existing OCD or related disorder that occurred prior to substance exposure
- Effects of OCD symptoms cause significant anxiety and distress, impairing functioning in everyday life
- Medication or substance-induced OCD is most commonly associated with people who abuse alcohol or drugs but can occur in anyone.

Etiology:

Repetitive, intrusive thoughts and compulsive behaviours associated with OCD and other related disorders can result from exposure to a variety of medications and substances including:

- Amphetamines (prescription) – often prescribed for ADHD or purchased and used illegally
- Antipsychotics (olanzapine) prescribed for schizophrenia
- Hypnotics (prescription), but sometimes used illicitly for recreation
- Sympathomimetic (i.e. epinephrine or norepinephrine) and other bronchodilators
- Anticholinergics
- Anticonvulsants (used for management of epilepsy)
- Thyroid medications
- Lithium (lithium carbonate) - used to treat a variety of mental illnesses
- Cannabis (marijuana)
- Cocaine, including crack and crystal methamphetamine
- Hallucinogens (i.e. LSD, mescaline, psilocybin mushrooms)
- Phencyclidine (PCP)
- Toxins – volatile and toxic substances, such as fuel, paint, nerve gases, carbon monoxide, lead, mercury, organophosphate insecticides

Drugs That Can Cause the Condition

Unlike many other substance- or medication-induced disorders, the number of substances that are recognized as causing obsessive compulsive is quite limited. They include:

- Amphetamine-induced obsessive compulsive disorder
- Other stimulant-induced obsessive compulsive disorder
- Cocaine-induced obsessive compulsive disorder

- Other substance-induced obsessive compulsive disorder
- Unknown substance-induced obsessive compulsive disorder

Treatment

Treatment may include stopping prescription medications determined to cause the OCD and replacement with a different drug. The doctor may also prescribe antidepressants commonly used in treating OCD and its related disorders.

Obsessive-compulsive disorder symptoms caused by medications, substance abuse, or toxin exposure typically subside or disappear completely once the responsible substance is identified and eliminated. Symptoms can continue until all of the substance or toxin leaves the individual's body.

OBSESSIVE COMPULSIVE AND RELATED DISORDERS DUE TO ANOTHER MEDICAL CONDITION

Diagnostic criteria

- A. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition
- B. The disturbance is not better explained by another mental disorder.
- C. The disturbance does not occur exclusively during the course of a delirium.
- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

- With Obsessive Compulsive disorder-like symptoms
- With appearance preoccupations,
- With hoarding symptoms
- With hair-pulling symptom
- With skin-picking symptoms

Causes

Certain medical conditions can cause psychiatric symptoms. Therefore, a medical evaluation should be performed to rule out a medical condition that might be causing the psychiatric symptoms.

For example, children with obsessive-compulsive disorder (OCD) should be tested for infections to rule-out Paediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS)

Treatment

If an individual's OCD behaviour arises due to a treatable organic illness, such as tinea capitis, acne vulgaris, or other skin or scalp condition, symptoms usually disappear once the underlying problem is treated. When the OCD occurs because of PANDAS, Wilson's disease, Pica, or other organic illness that isn't fully understood, treatment can prove more challenging.

These treatments include

- Medication therapy with selective serotonin uptake inhibitors (SSRIs).
- Cognitive behavioural therapy as both work to help people manage symptoms and compulsive urges.

OTHER SPECIFIED OBSESSIVE COMPULSIVE AND RELATED DISORDERS

This category applies to presentations in which symptoms characteristic of an obsessive compulsive and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the obsessive-compulsive and related disorders diagnostic class.

Examples of presentations that can be specified using the other specified" designation include the following:

1. **Body dysmorphic-like disorder with actual flaws:** This is similar to body dysmorphic disorder except that the defects or flaws in physical appearance are clearly observable by others (i.e., they are more noticeable than "slight"). In such cases,
2. **Body dysmorphic-like disorder without repetitive behaviours:** Presentations that meet body dysmorphic disorder except that the individual has not performed repetitive behaviours or mental acts in response to the appearance concerns.
3. **Body-focused repetitive behaviour disorder:** This is characterized by recurrent body focused repetitive behaviours (e.g., nail biting, lip biting and cheek chewing) and repeated attempts to decrease or stop the behaviours.

4. **Obsessional jealousy:** This is characterized by non-delusional preoccupation with a partner's perceived infidelity.
5. **Shubo-kyofu:** A variant of taijin kyofusho (see "Glossary of Cultural Concepts of Distress" in the Appendix).that is similar to body dysmorphic disorder and is characterized by excessive fear of having a bodily deformity.
6. **Koro:** Related to dhat syndrome, an episode of sudden and intense anxiety that the penis (or the vulva and nipples in females) will recede into the body, possibly leading to death.
7. **Jikoshu-kyofu:** A variant of taijin kyofusho characterized by fear of having an offensive body odour (also termed olfactory reference syndrome).

UNSPECIFIED OBSESSIVE COMPULSIVE AND RELATED DISORDERS

This category applies to presentations in which symptoms characteristic of an obsessive social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the obsessive-compulsive and related disorders diagnostic class. The unspecified obsessive-compulsive and related disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific obsessive-compulsive and related disorder, and includes present citations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).