Unit6 :Obsessive Compulsive and related Disorders

Obsessive compulsive disorder (was previously classified as an anxiety disorder due to the sometimes extreme anxiety that people experience However, it varies from other anxiety disorders in significant ways Certain disorders characterized by repetitive thoughts and/or behaviors, such as OCD, can be grouped together and described in terms of an obsessive-compulsive spectrum:

The spectrum approach includes Repetitive behaviors of various types

1. Self-soothing behaviors, such as trichotillomania, dermatillomania or onychophagia
2. Reward seeking behaviors, such as hoarding, kleptomania, pyromania, or oniomania.
3. Disorders of body appearance or function, such as body dysmorphic disorder (BDD).

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5 diagnoses include

1. Obsessive compulsive disorder (OCD).
2. Body dysmorphic disorder (BDD(.
3. Hoarding disorder.
4. Trichotillomania (hair pulling).
5. Excoriation (skin picking).
6. Disorders due to substances and medication

1. **Obsessive compulsive disorder (OCD):**

Obsessions are recurrent, persistent, intrusive, and unwanted thoughts, images, or impulses that cause marked anxiety and interfere with interpersonal, social, or occupational function

Compulsion: uncontrollable impulse to perform an act repetitively

Common compulsions include the following:

1. Checking rituals (repeatedly making sure the door is locked or the coffee pot is turned off).

2. Counting rituals.

3. Washing and scrubbing until the skin is raw.

4. Praying or chanting.

5. Touching, rubbing, or tapping (feeling the texture of each material in a clothing store touching people, doors, walls, or oneself).

6. Ordering (arranging and rearranging furniture or items on a desk or shelf into perfect order vacuuming the rug pile).

7. Having aggressive urges (for instance, to throw one's child against a wall).

Onset and Clinical Course

•OCD can start in childhood, especially in males.

•In females, it more commonly begins in the 20s.

•Overall, distribution between the sexes is equal.

•Onset is typically in late adolescence, with periods of waxing and waning symptoms over the course of a lifetime.

•Early onset is more likely to affect males, has more severe symptoms, more comorbid diagnoses, and a greater likelihood of a family history of OCD.

2. Body dysmorphic disorder (BBD) is a preoccupation with an imagined or slight defect in physical appearance that causes significant distress for the individual and interferes with functioning in daily life. The person ruminates and worries about the defect, often blaming all of life's problems on his or her "flawed" appearance, that is, the appearance is the reason the person is unsuccessful at work or finding a significant other, for feelings of unhappiness, and so forth.

-Elective cosmetic surgery is sought repeatedly to "fix the flaw," yet after surgery, the person is still dissatisfied or finds another flaw in his or her appearance. It becomes a vicious cycle.

-Treatment with selective serotonin reuptake inhibitors (SSRIs) has been effective in relapse prevention.

3. Hoarding disorder is a progressive, debilitating, compulsive disorder only recently diagnosed on its own. Hoarding had been a symptom of OCD previously but differs from OCD in significant ways. Diagnosis most commonly occurs between the ages of 20 to 30.

-The prevalence and severity of the disorder is 2% to 5% of the population and increases with age. It is more common in females, with a parent or first-degree relative who hoards as well (Dozier, Porter, & Ayers, 2016).

•Hoarding involves excessive acquisition of animals or apparently useless things, cluttered living spaces that become uninhabitable, and significant distress or impairment for the individual.

-Treatment and interventions can be medication, cognitive–behavioral therapy (CBT), self-help groups, or the involvement of outside community agencies. Not a great deal is known about the success of these approaches at this time.

4. Trichotillomania, or chronic repetitive hair-pulling, is a self-soothing behavior that can cause distress and functional impairment.

-Onset in childhood is most common, but it can also persist into adulthood with the development of anxiety and depression.

-It occurs more often in females than in males.

-Trichotillomania can be successfully treated with behavioral therapy.

5. Excoriation disorder, skin-picking, also known as dermatillomania, is categorized as a self-soothing behavior; that is, the behavior is an attempt of people to soothe or comfort themselves, not that picking itself is necessarily a positive sensation.

-The behavior can cause significant distress to the individual and may also lead to medical complications and loss of occupational functioning.

-It may be necessary to involve medicine, surgery, and/or plastic surgery, as well as psychiatry on the treatment team.

-Alternative therapies, such as yoga, and acupuncture, are helpful when included in the treatment plan.

-**Onychophagia, or chronic nail-biting**, is a self-soothing behavior. Typical onset is childhood, with a decrease in behavior by age 18. However, some nail-biting persists into adulthood. It may lead to psychosocial problems or cause complications involving the nails and oral cavity. SSRIs have proven effective in the treatment of onychophagia.

−Oniomania, or compulsive buying, is an acquisition type of reward seeking behavior. The pleasure is in acquiring the purchased object rather than any subsequent enjoyment of its use.

-Spending behavior is often out of control, well beyond the person's financial means. And, once acquired, the object may be infrequently or never used.

-Approximately 80% of compulsive buyers are females with onset of the behavior in the early 20s; it is often seen in college students. Compulsive shopping runs in families who also have a high comorbidity for depression and substance use.

Treatment:

1. Optimal treatment for OCD combines medication and behavioral therapy

2. SSRI and antidepressants, such as fluvoxamine (Luvax) and sertraline (Zoloft), are first line choices, followed by venlafaxine (Effexor).

3. Treatment resistant OCD may respond to second generation antipsychotics such as risperidone (Risperdal) quetiapine (Seroquel) or olanzapine (Zyprexa).

4. Behavioral therapy specifically includes exposure and response prevention

5. Other techniques, such as deep breathing and relaxation

Nursing intervention

1. **Provide safety:**

Patients with OCD may have violent and intrusive thoughts of harming someone or themselves. The nurse may need to remove objects that could be used to cause injury, or the patient may need supervision.

2. Start cognitive-behavioral therapy.

Cognitive behavioral therapy (CBT) is recommended as the first-line treatment for OCD. Talk therapy focuses on thoughts, feelings, and behaviors and can be beneficial for both OCD and anxiety or other mental health comorbidities.

3. Encourage relaxation.

Symptoms can be stressful to a patient with OCD. Stress can be relieved by activities like yoga, meditation, and massage.

4. Administer SSRIs as ordered.

Selective serotonin reuptake inhibitors are medications prescribed to manage obsessions and compulsions and reduce anxiety.

5. Consider other treatment options.

If OCD is uncontrolled by psychotherapy or medications, newer treatments may be considered. Deep Transcranial Magnetic Stimulation non-invasively stimulates nerve cells using magnetic fields to alleviate symptoms of OCD.

CLIENT AND FAMILY EDUCATION For OCD For Clients

➢Teach about OCD.

1.Review the importance of talking openly about obsessions, compulsions, and anxiety.

2.Emphasize medication compliance as an important part of treatment.

3.Discuss necessary behavioral techniques for managing anxiety and decreasing prominence of obsessions.

4.Tolerating anxiety is uncomfortable but not harmful to health or wellbeing.

❑For Families

1.Avoid giving advice such as, “Just think of something else.”

2.Avoid trying to fix the problem; that never works.

3.• Be patient with your family member’s discomfort.

4.• Monitor your own anxiety level, and take a break from the situation if you need.

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