



Obsessive Compulsive and related Disorders

University of Al-ameed/ College of Nursing



Learning Objectives

- 1. Discuss etiologic theories of obsessive compulsive disorder (**
- 2. Describe related compulsive disorders, including self-soothing and rewardseeking behaviors and disorders of body appearance and function**
- 3. Apply the nursing process to the care of clients and families with OCD**
- 4. Evaluate your feelings, beliefs, and attitudes regarding OCD 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 (hairpulling).
5. Excoriation (skin picking).
6. Disorders due to substances and medication.



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



❑ **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.



- **Body dysmorphic disorder (BDD)** 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.



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- ❑ **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.



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- ❑ **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, although results are mixed and long-term outcomes are not well documented.



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- ❑ **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, acupuncture, and biofeedback, 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**.



- ❑ **Body identity integrity disorder (BIID)** is the term given to people who feel “**overcomplete**,” or alienated from a part of their body and desire **amputation**. This condition is also known as amputee identity disorder and apotemnophilia or “amputation love.” This is not an officially APA-accepted diagnosis, and there is disagreement about the existence of the condition.
- People describe feelings of anguish and **distress** with their intact bodies and report feeling “**natural**, like they were intended to be” **after an amputation**.
- People with BIID resort to actions such as packing the limb in **dry ice** until the **damage** is so advanced that amputation becomes a medical necessity, or in some cases, amputation is done with a power tool by nonmedical persons, leaving a physician to save the person’s life and mitigate with the damage.



❑ ✓ Etiology

1. The cognitive model describes the person s thinking as:

(1) Believing one's thoughts are overly important.

(2) perfectionism and the intolerance of uncertainty.

(3) Inflated personal responsibility (from a strict moral or religious upbringing) and overestimation of the threat posed by one's thoughts.

2. Population-based studies have confirmed substantial heritability in OCD.

3. Genome wide and candidate gene association studies have found variations that may be involved in OCD pathology:



Treatment:

- Optimal treatment for OCD combines medication and behavioral therapy
 - ✓ 1. SSRI and antidepressants, such as fluvoxamine (Luvax) and sertraline (Zoloft), are first line choices, followed by venlafaxine (Effexor).
 - ✓ 2. Treatment resistant OCD may respond to second generation antipsychotics such as risperidone (Risperdal) quetiapine (Seroquel) or olanzapine (Zyprexa).
 - ✓ 3. Behavioral therapy specifically includes exposure and response prevention
 - ✓ 4. Other techniques, such as deep breathing and relaxation



Implementation with OCD

| Nursing Interventions | Rationale |
|---|---|
| 1. Observe the client's eating, drinking, and elimination patterns, and assist the client as necessary. | 1. The client may be unaware of physical needs or may ignore feelings of hunger and thirst. |
| 2. Assess and monitor the client's sleep patterns, and prepare him or her for bedtime by decreasing stimuli and providing comfort measures or medication. | 2. Limiting noise and other stimuli will encourage rest and sleep. Comfort measures and sleep medications will enhance the client's ability to relax and sleep. |
| 3. Need to allow extra time, or the client may need to be verbally directed to accomplish activities of daily living (personal hygiene and preparation for sleep). | 3. The client's thoughts or ritualistic behaviors may interfere with or lengthen the time necessary to perform tasks. |



Implementation with OCD

| Nursing Interventions | Rationale |
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| 4. Encourage the client to try to gradually decrease the frequency of compulsive behaviors. | 4. Gradually reducing the frequency of compulsive behaviors will diminish the client's anxiety and encourage success. |
| 5. As the client's anxiety decreases and as a trust relationship builds, talk with the client about his or her thoughts and behavior and the client's feelings about them. Help the client identify alternative methods for dealing with anxiety. | 5. The client may need to learn ways to manage anxiety so that he or she can deal with it directly. This will increase the client's confidence in managing anxiety and other feelings. |
| 6. Convey honest interest in and concern for the client. Do not flatter or be otherwise dishonest. | 6. Your presence and interest in the client convey your acceptance of the client. Clients do not benefit from flattery or undue praise, but genuine praise that the client has earned can foster self-esteem. |



❑ **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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