Basics of Mental Health and Clinical Psychiatry
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Lecture 18
Anxiety Disorders - II

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Hello, everyone. Let us start lecture number 18 Anxiety Disorders Part 2.

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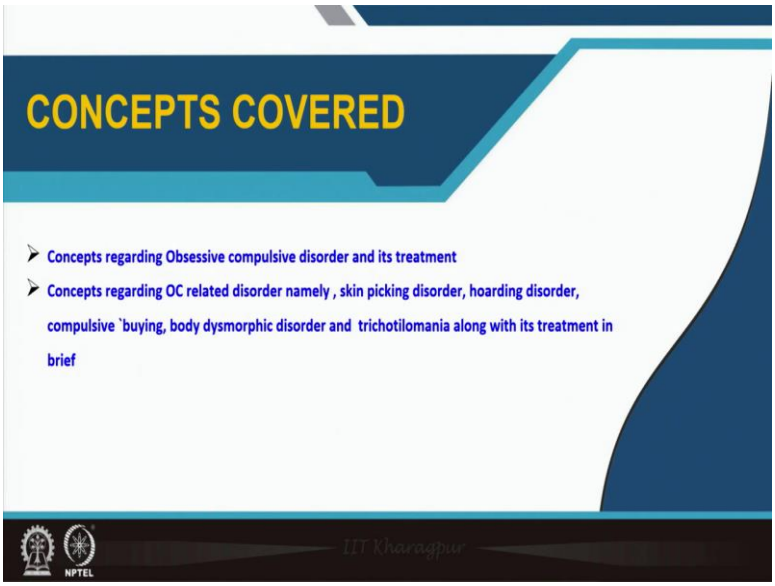

So, in this, we will be discussing about the concepts of obsessive compulsive disorder, its management and obsessive compulsive related disorders like hoarding disorder, trichotillomania, skin picking disorders, and what it is mopping disorders and its management.

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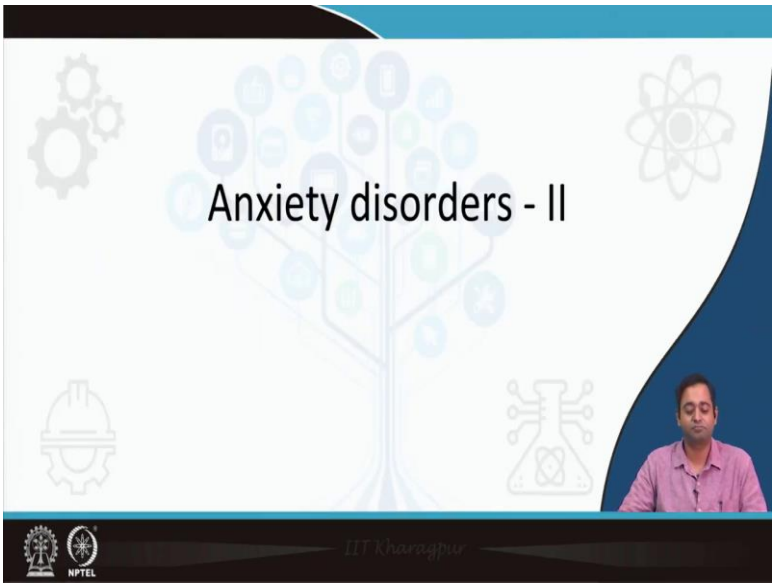

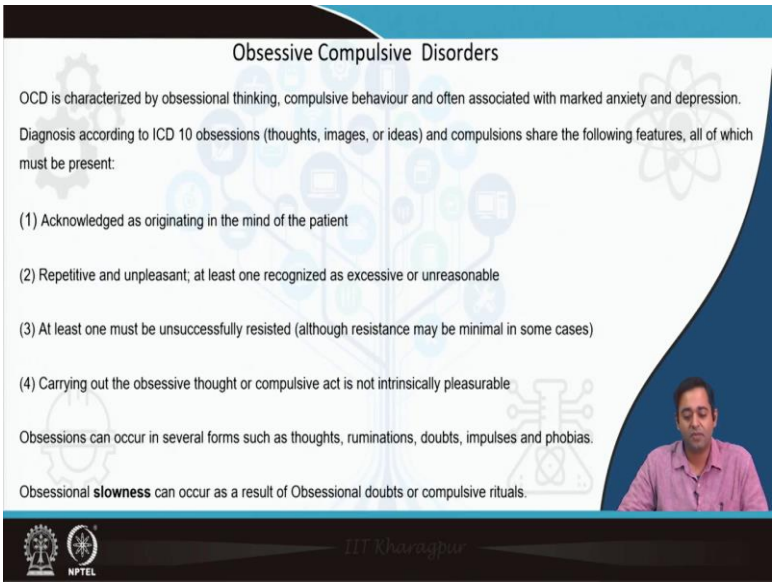

So, what is an obsessive and compulsive disorder? Now, you have two components, you have an obsession and you have a compulsion. Now, what is an obsession? Obsession is those thoughts which actually compels you to do a particular kind of acts. Since, there are two components, obsessions and compulsions. Compulsions are a compulsive acts, behaviors.

And obsessions are used repetitive recurrent, intrusive, irrational, thoughts, which compels you to do a act or a behavior. So, this OCD is obsessions and compulsions they the symptoms, which should be present for a period of 15 days, 2 weeks, 14 days, in order to diagnose a patient suffering from obsessive compulsive disorder.

Now, they can have three types, you can have mixed obsession, as well as compulsion, you can either have a compulsion you can either have an obsession. So, what are these

obsessions? These can be thoughts, these can be images, or an ideation. And compulsions, as you know, it can be acts of compulsion, behaviors, which is being done repetitively in order to avoid those intrusive obsessions.

Now, five components has to be there, those repetitive, the negative thoughts are repetitive in nature, they are intrusive in nature, they are irrational, they are ego dystonic they are not yours. But even though it is not your thought, you have to exercise you have to execute your thought process, you have to do the compulsive act. And lastly, the irrationality of the thought. So, even though you know this act of mine will not give me a relief. But even though you tend to continue and went on to execute the present ongoing act.

So, these are acknowledged as originated in the mind of the patient. They are representative and present at least one recognized as excessive or unreasonable. They carrying out the obsession thought or compulsive act is not intrinsically pleasurable. So, obsessions can occur in several forms, such as thoughts, ruminations, doubts, impulses and phobias. Obsessional slowness can occur as a result of obsessional doubts or compulsive rituals.

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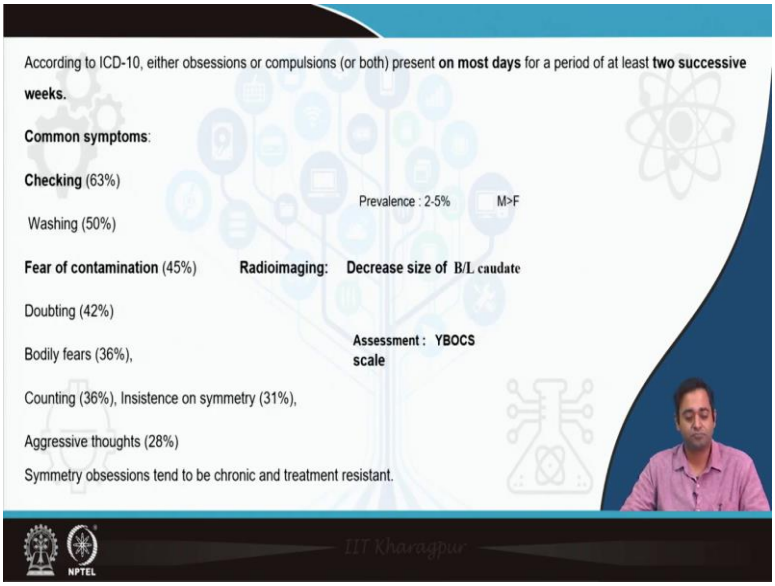

Now, according to this ICD as I told you, put in two weeks has to be present. What are the common symptoms? The common, the most common is the checking. Second is washing, fear of contamination, doubting, body fears, counting, aggressive thoughts, symmetric obsessions. Now, most commonly seen or like complaints given by the patient is like for contamination and dirt and checking and doubting, the patient presents with telling I am washing my hands more than 100 times a day and the thought process whenever the patient presents with thoughts of contamination and dirt.

So, in this contamination and dirt patient can have those repetitive thoughts of dirtying his hands. So, even though he washes his hands, the mind tells the brain tells, no your hands are still dirty and you need to wash your hands again. So, you have a relative changes that occur along with this process, this negative thought process, you do not allow your family members to have a normal day to day life activities, your child, your spouse, your grandparents, your father in law, your mother in law, whoever are staying with that patient, they are actually in big emotional problems or emotional crisis because the day to day life activities are hampered.

The child whenever it goes to school, suppose if a female is suffering from OCD, who is a middle aged somewhere around 40 to 45 and he experiences this contamination of dirt that my hands are dirty I should not touch anything. Otherwise, I will be having a very severe kind of, I will contact a very severe kind of infection. So, he does not, she does not allow her spouse, her child or the family members living at home, to touch any of those things which she feels might give rise to contamination or a severe kind of illness.

So, the spouse is he comes from office in the evenings he will ask she will ask her to get yourself washed, get yourself clothes, your wash should be closed properly, you should go and take bath. Your child when they come from, whenever her children, they come from school, they are allowed to open their shoes and clothes wash them properly.

Even her bed the female who is suffering from obsessive compulsive disorder her bedsheets are changed everyday, washed thrice a day. So, the severity of the illness is so much so that it makes the life not livable for the family. So, what is the obsession here in dirt and contamination, obsession is the obsession of dirt. So, what is the compulsion here, you tend to wash. So, this is obsessive and compulsive disorder.

Now, what happens in checking and doubting where you are suppose if this female if suffers, if she suffers from OCD of checking and doubting, she will repeatedly things that even though she has cooked her food properly, she has not put down the gas and she goes on and check more than 1000 times or she goes out while locking the house she goes out in the market and comes back to check more than 100 times I have correctly placed a lock at my home or not. So, these kinds of activities it goes on for the whole day. And that is how there is obsessive slowness.

The acts which it makes the person slow, slow means you are actively involved in the thought process and the compulsive acts, which actually makes your day to day life miserable and it

makes your life miserable for you to live on. So, these are the consequences which the patient might be suffering from.

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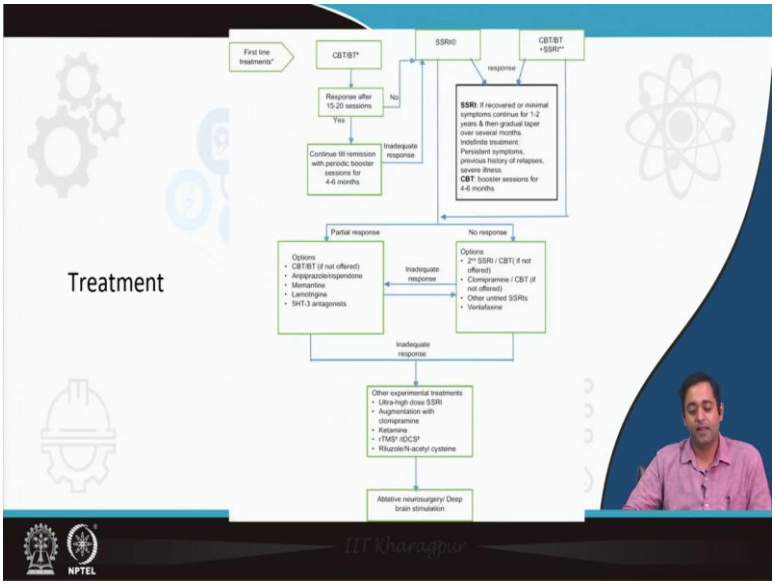

How do you treat this obsessive compulsive disorder? Now, if a patient who is suffering from OCD who is diagnosed with OCD, he should be, he or she should be started first with a behavior therapy. Now, behavior therapy is like associated with systemic desensitization or it is done with therapeutic graded exposure or it is done with cognitive therapy. So, if this behavior therapy does not, if it does not give relief to the patient, then the indication for medicines comes in.

Now, for medicines SSRIs selective serotonin reuptake inhibitors, they are most the evidence is most strong for SSRIs. They have to be given for a period of 6 weeks. And if there is no response with any of the class of the SSRIs the clomipramine TCA is being changed or it is being preferred.

So, if the patient does not respond with clomipramine and associated with SSRIs, or like on and off with SSRIs they are given, they are augmented with anti-psychotics, Risperidone and Aripiprazole are like they have most of the evidences are with Risperidone and Aripiprazole. If they do not have these effects, with all those, these medicines, they are augmented with 5HT-3 antagonists or Lamotrigine or at times with lithium.

If all these medicines, they do not suffer, they do not give relief of symptoms to this, to the patient. Other experimental treatments are given like ketamine or rTMS and sometimes N-

acetyl cysteine is also given. And if none of these gives relief to the symptoms to the patient, deep brain stimulation can be given which can have good results.

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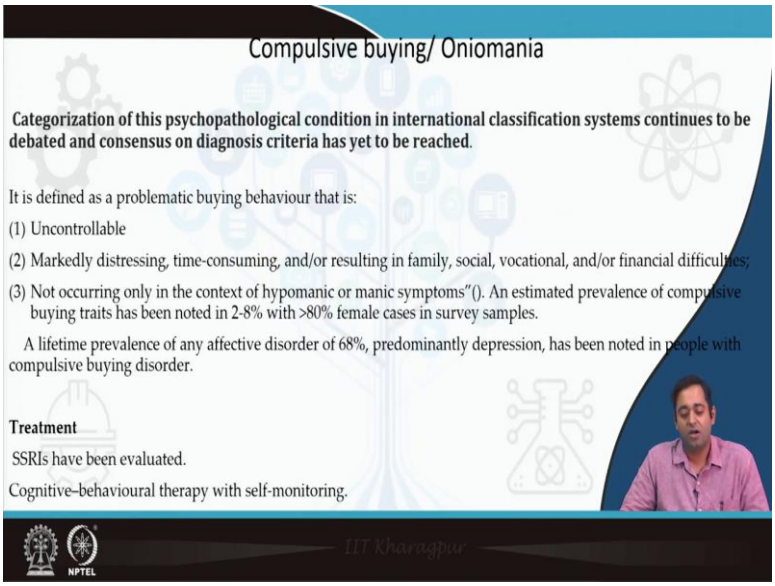

What are OCD related disorders? Now, OCD related disorders means, the symptomatology the phenomenology of the patient is similar to what the patient of OCD suffers from. Now, he can, he or she might be experiencing those same obsessions, those same kinds of compulsive acts. So, those are negative thoughts, those repetitive in nature, the irrationality of your thought process your ego dystonicity your thought process, where the person feels that okay whatever there was those negative thoughts, which is coming to my brain, to my mind, is actually not real.

It is not me who is thinking but even though I have to execute the act in order to get relief, even though there is no relief of the symptoms, even though the patient continues to or went out, went on to continue the act. Now, categorization of this psycho pathological condition in international classification systems continues to be debated and consensus on diagnosis criteria has yet to be reached.

What is that? It is a defined as a programmatic buying behavior that is uncontrollable, markedly distressing, time consuming, resulting in family social vocation and financial difficulties. Not occurring only in context of hypomanic or manic symptoms and estimated prevalence of this has to be noted somewhere between 2 to 8 percent females are commonly seen with this.

So, compulsive buying or oniomania is having a lifetime prevalence of 68 person with any affective disorder and they are most commonly predominantly affected with depression. Treatment is with SSRIs and CBT.

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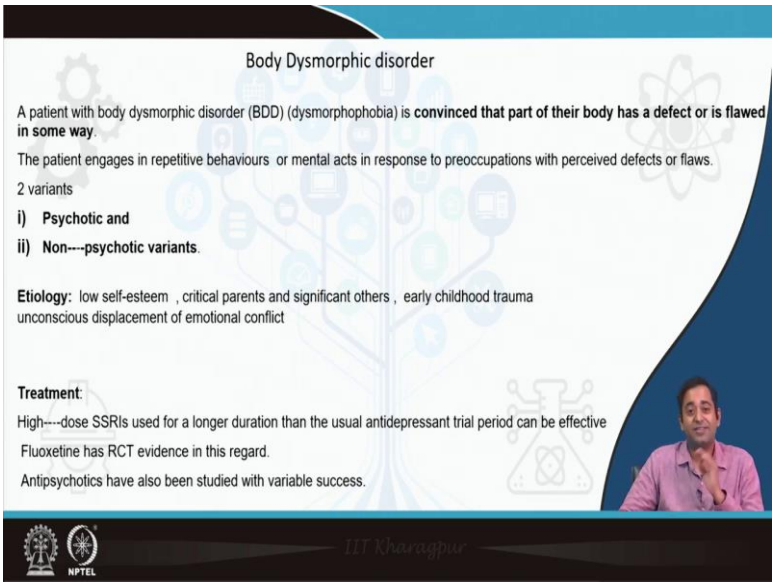

What is body dysmorphic disorder? Body dysmorphic disorder is when the patient is actually experiencing feeling that specific body part is D shaped it is not a normal shape like normal persons. Specifically, the nose is bigger or a chin is pointer or any kind of disfigurement of your body part is present, even though he or she might have a normal body shape.

So, patient with body dysmorphic disorder is convinced that part of their body has a defect and is flawed in some or the either way. Patient engages in repetitive behavior or mental acts

in response to preoccupation with perceived defects or flaws. There are basically two variants psychotic and non-psychotic variants.

So, psychotic variants is treated with the help of antipsychotics, where they are convinced there is a delusion that okay this particular nose of mine is not in a particular shape, this chin of mine is not in a particular shape, my cheeks are not in a particular shape, my hands are not in particular shape. So, where there is a delusion which has occurred, so that leads to a psychotic phenomenon.

What are the etiologies that is associated with body dysmorphic disorders? Low self-esteem, critical parents, and early childhood trauma, unconscious displacement of emotional conflict. How are they treated? High dose SSRIs are given for a longer duration than the usual antidepressant trial period. Flow routine has RCT evidence and antipsychotics are given for psychotic as a preoccupation with the body dysmorphic disorders.

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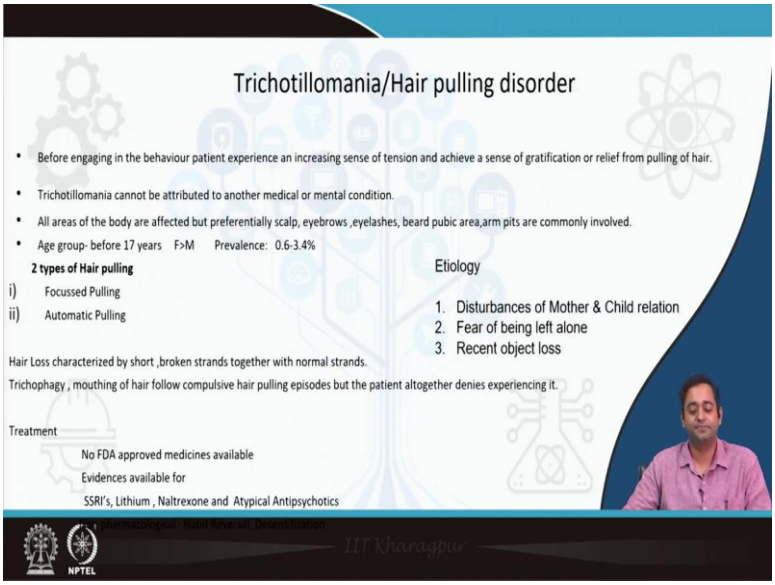

Trichotillomania. Now, what is trichotillomania? Trichotillomania is when the person is having compulsive hair pulling phenomenas. Before engaging in the behavior, patient experience and an increased sense of tension and achieve a sense of gratification or relief from pulling of the hair. So, there can be patients who have this intense feeling of tension or irritability agitated so they are trying to control this kind of feeling.

But even though they are not able to stop the impulse is so high that they have to pull their hair and after pulling their hair there is this feeling of gratification or feeling of good (())(13:20), which actually happens when he or she when the patient has actually pulled a lot

of hair follicles. Now, all either of the body are commonly affected preferentially the scalp, eyebrows, eyelashes, beard, pubic area, armpits.

Two types of hair pulling are seen that is focused hair pulling and automatic head pulling. Automatic is when unconsciously you try to pull out your hair. And focus is when specifically, the hand goes in for a scalp or eyebrows or eyelashes and all. Etiologies disturbances of child-mother relatable experiences in the early childhood age groups, fear of being left alone, abandoned in the early part of your childhood or recent object loss.

Recent object loss means, if the person who had a very prized possession or a person or teenager who has just lost his bike or he has just lost his somewhat he was very close to. So, that can give rise to Trichotillomania or hair pulling disorder. Hair loss is characterized by short broken strands together with normal strands. So, now, there can be group of heads which is normal and just beside it or in the vicinity you can have short broken strands also.

They can be trichophagy, mouthing of hair, followed by a compulsive hair pulling episodes but the patient together denies experiencing it. Now, why is there because suppose if a patient who is having trichotillomania, he or she is trying to pull his hair, pull her hair and sometimes there are relatable experiences where the patient went on to eat those hairs also and develop (())(15:08). And in the stomach and all where there is a collection of the hair also.

So, and when the patient is being confronted with this particular kind of experiences or situation, he altogether denies doing this compulsive act or the behavior. Treatment as there is no FDA medicines available, but evidences are that SSRIs have known to counteract this kind of condition along with opioid antagonists also Naltrexone.

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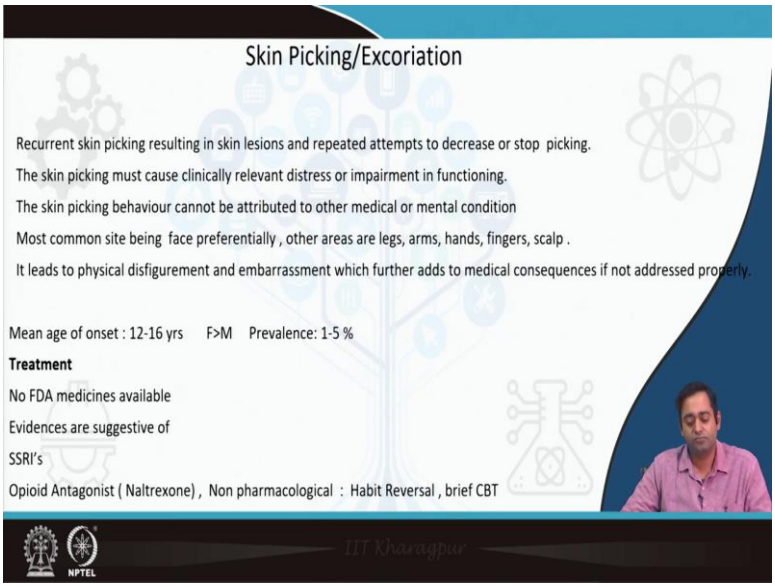

Now, what is skin picking or excoriation? It is a recurrent skin picking resulting in skin lesions and repeated attempts to decrease a stop. Now, what are the areas where the skin picking most commonly seen? These are the chin, preferentially face, areas of the arms, legs, fingers or scalp. And the skin picking disorder this excoriation this must clinically cause relevant distress, socio occupation impairment for the patient.

And it cannot be attributed by any other medical condition or other psychiatric illnesses. Mean age of onset is for 12 to 16 years, females are commonly implicated and prevalence is 1 to 5 percent. Treatment, as this is a newer addiction, like these all behavioral addictions, they are newer accompaniment in the DSM the treatment strategies are very less there is as such no evidence for any drug which is specific drug which can actually treat these conditions.

So, as other behavioral addictions, this SSRIs and opioid antagonists like Naltrexone, they are being tried for some successful outcomes. In psychological therapy, habit reversal and brief CBT can also be given for this kind of patients who are suffering from skin picking or excoriation.

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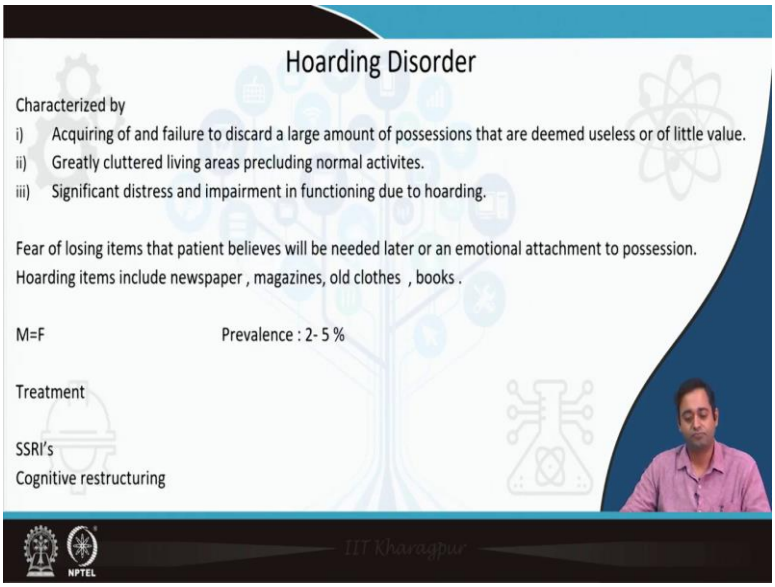

What is hoarding? Now, you have seen now among all this behavioral addictions, hoarding is most common among all this now, because from our early childhood, we have like when we were young or even now also from class 1 till 10, we have all our textbooks which we try to accumulate and try to see keep and try to keep with ourselves at times that this books will be used somewhat in the later part of your life in somewhat in the future, where this books might be reusable.

So, we try to get associated, we try to get close to or have an emotional bonding with this kind of materials. So, the person is actually having failure to discard a large amount of possessions that are deemed useless or a futile value. Now, for them. Those kinds of possessions they are even though they are a futile value, they are not able to discard from their life. Greatly, cluttered living they do not have any space, but even though they are trying to hold those objects or those substances at home. There is significant distress and impairment in the social occupational functioning of that patient.

Fear of losing items that patient believes will be needed later or an emotional attachment to possession. Now, there are this fear that is why it allows or it propels the patient not to discard them. Now, hoarding items as I was telling you can be books, newspapers, old clothes at times also, and magazines. Females and males, they tend to have they both can have this kind of psychiatric illness. Treatment is with SSRIs and cognitive restructuring.

Now, what is cognitive restructuring? In cognitive restructuring your thought process, your analyzation of your thought process is being transformed and you are being told to have some alternative solutions to your thought process means now suppose take a situation for a old

lady who is waiting for a daughter or a mother who is waiting for a son or a boss was waiting for his client or colleague to at office.

So, for all these circumstances, if there is stipulated time, a time period for which all are waiting, like by 6 o'clock, this person might be here, by 6 o'clock my daughter should be here. Now, if this, if the clock struck six, and the mother, the boss and the grandmother they all can have all sorts of anticipations all sorts of things. They are their provoked ideation that why he why she has not returned home because the time has already been there.

So, they can be, your, the thought process can be so detrimiting (ph). So, this that it creates a sort of emotional numbing for the patient. So, what will cognitive restructuring do? It will try to have or it will try to tell the patient to create a sort of alternative solutions like you have to think at that point of time that okay my granddaughter, my son, my colleague or my friend must have been in some situation in which he or she is not able to inform us, it is not that he might have died.

So, that is the most dreadful thing which we actually perceive in those kinds of situations, there are maximization of the thought process. So, we actually see for the worst part mostly, so there we have to create alternative kind of solutions that he might be in some traffic signal, he or she might be doing some important work for which at that point of time there was no time to actually communicate and tell, I will be late for some 5 or 10 minutes. This is actually the cognitive restructuring.

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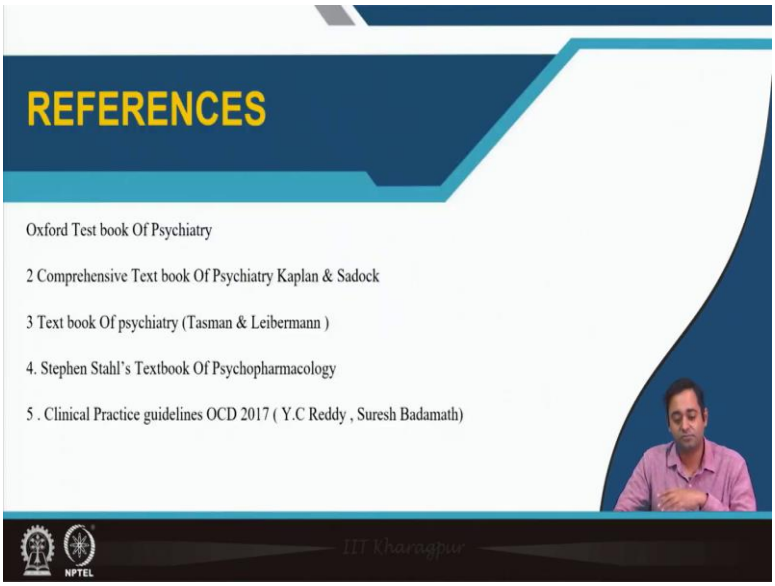

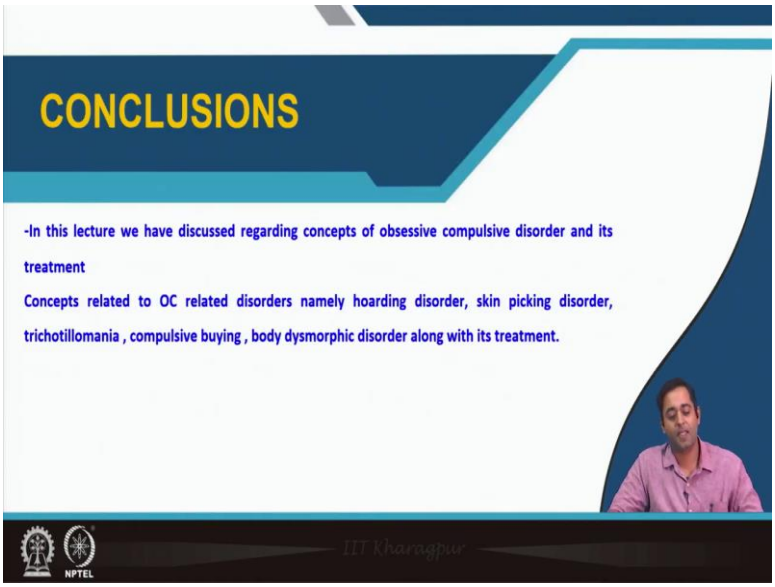

So, in this lecture, we have discussed regarding the concepts of obsessive compulsive disorders, related disorders, hoarding disorder, skin picking your body dysmorphic phobias, and its related matter management techniques.

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Thank you.