OBCESSIVE COMPULSIVE AND RELATED DISORDERS

1 Obcessive compulsive disorder (OCD)

- DSM-5:
  1. time consuming obsessions / compulsions (>hr/day) that cause significant distress/dysfxn.
     - obssessions → recurrent intrusive anxiety provoking thoughts, images, urges that pt attempt to suppress, ignore, neutralize by an action (compulsion)
     - compulsion → repetitive behaviors or mental acts in response to obsession to reduce stress, behaviors are excessive & not realistically connected to what meant to be prevented
  2. not due to substance or medical condition

- epidemiology: equal bet. genders
- etiology: significant genetic component
  (higher in 1st degree relatives & monozygotic twins, higher if 1st degree has Tourette's disorder)

- Course, prognosis:
  - ↳ Chronic episodic (<20% remission if not treated)
  - ↳ 50% suicidal ideation & 25% attempt
  - ↳ ↑ comorbidities with other disorders (anxiety, bipolar, depressive, OCPD, tics)

- common obsessions & compulsions:
  1. contamination → cleaning, avoiding contamination
  2. doubt/harm → check multiple times to avoid danger
  3. symmetry → ordering/counting
  4. intrusive/taboo thoughts

- treatment:
  1. CBT → exposure & response prevention
  2. psychopharma
     - ↳ SSRIs (sertaline, fluoxetine) → 1st line, high doses
     - ↳ 2nd line → SNRIs (venlafaxine) or serotonin selective TCA, clomipramine
     - ↳ add atypical antipsychotics if severe
  3. psychosurgery (cingulotomy) or ECT → if treatment resistant

- OCD vs. OCPD
  OCD → distressed by their symptoms (ego dystonic)
  OCPD → obsessed w/ details, control & perfectionism w/ out experiencing unwanted preoccupations or compulsions

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2 body dysmorphic disorder

- DSM-5
  1. preoccupied w/ non existant or minor physical defects
  2. spend significant time trying to correct flaws (makeup, dermatological or plastic procedures)
  3. repetitive behaviors (skin picking, excessive grooming) or mental acts (compairing self to others)
  4. Sig. distress / fxn impairment
  5. eating disorder حلة مش مفهومة بس الفكرة نفرق بينها و بين الـ

- epidemiology
  - more in ♀, history of child abuse/ neglect, 1st degree relatives w/ OCD
  - higher in dermatologic & plastic surgery pts
  - mean onset age: 15

- course / prognosis
  - gradual, chronic
  - cosmetic procedures don't satisfy pt
  - suicidal ideation / attempts
  - + MDD, social anxiety, OCD

- treatment: SSRIs / CBT

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3 hoarding disorder

- DSM-5
  1. difficulty discarding possessions regardless of value & distress associated w/ discarding
  2. accumulation of possessions that congest living area
  3. Sig. distress / fxn impairment
  4. not due to medical or other mental disorder

- epidemiology
  - ↳ more in elderly
  - ↳ may be preceeded by stressful/traumatic event
  - ↳ 50% have hoarding relative

- course / prognosis:
  - ↳ begins in early teens, progressive.
  - ↳ mostly + MDD, social anxiety, OCD

- treatment
  very difficult, CBT, SSRIs

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4 trichotillomania

- DSM-5:
  1. recurrent hair pulling → hair loss
  2. repeated attempts to stop
  3. sig. stress / fxn impairment
  4. not due to medical or other mental disorder
  5. involve scalp, brows, lashes, even facial, axillary, pubic

- epidemiology:
  - ↳ more in ♀
  - ↳ onset at puberty, mostly after stressful event
  - ↳ biological, genetic, environmental factors
  - ↳ + OCD, MDD, excoriation (skin picking)
  - ↳ chronic, episodic, adult onset is more difficult to treat

- treatment
  - ↳ CBT (habit reversal training, recommended)
  - ↳ SSRIs, 2nd gen antipsychotics, lithium, N acetylcystine.

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5 excoriation (skin picking)

- DSM-5
  1. skin picking → lesions
  2. + 3 + 4 → same as hair picking

- epi: more in ♀ & pts w/ OCD, trichotillomania, MDD
- course: begins in adolescence, chronic, episodic
- treatment: CBT (habit reversal training), SSRIs

6 post traumatic stress disorder (PTSD) & acute stress disorder

- PTSD: development of multiple symptoms after traumatic event (intrusive symptoms like nightmares, flashbacks or avoidance, negative thoughts/mood, increased arousal), last ≥ 1mo., begins immediately or delayed (3 mo.) after trauma

- Acute stress disorder: same as PTSD but < 1 mo., begins immediately after trauma

- DSM-5:
  1. exposure to life threatening event, serious injury, sexual violence (experiencing or witnessing)
  2. recurrent intrusions of re experiencing, distress when exposed to cues.
  3. avoidance of triggering stimuli (memory, feeling, people place, object)
  4. at least 2 of negative cognitions/mood: dissociative amnesia, negative feeling of self/others/world, self blame, negative emotions (fear, anger, guilt), anhedonia, feeling of detachment/estrangement, inability to experience positive emotions
  5. at least 2 of increased arousal/reactivity: hypervigilance, exaggerated startle response, irritability, angry outbursts, impaired concentration, insomnia
  6. not by substance/medical/other mental disorder
  7. sig fxn impairment
  8. presentation differs in children < 7 years.

- epi: more in ♀, events like rape/interpersonal violence or childhood trauma
- course: 50% PTSD pts have full recovery after 3 mo., diminish in older age
- most pts → + MDD, bipolar, anxiety, substance use

- Criteria of PTSD: TRAUMA
  Traumatic event, Reexperience, Avoidance, Unable to fxn, Month or more, Arousal increased

- treat:
  1. SSRI (sertaline), SNRI (venlafaxine)
  2. prazosin α_1 receptor antag. for nightmares & hypervigilance
  3. 2nd gen antipsychotics (for severe / resistant)
  4. CBT (exposure, cognitive processing therapy), supportive psychodynamic therapy, couple/fam. therapy

avoid benzos cuz of high rate of substance use disorders & lack of efficacy

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7 Adjustment disorders

- DSM-5:
  1. development of symp. within 3 mo. after stressful event (excessive distress about event, fxn impaired) but the event isn't life threatening as PTSD
  2. symptoms don't support normal bereavement or other mental disorder
  3. symp. resolve 6 mo. after stressor is terminated

- subtypes: based on predominance (depressed, anxiety, disturbance of conduct (agression), mixed)

- epidemiology letiology:
  - in 5-20% of mental health pts
  - any age
  - psychosocial factors

- prognosis: chronic if stressor is chronic

- treat:
  1. supportive psychotherapy, group therapy
  2. pharmacotherapy for insomnia, anxiety, depression