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# Obsessive-Compulsive Disorder

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## Abstract

Psychological care is just like physical care, it should not be neglected because it will tire the person himself and affect his entire life. Mental health is linked to physical health and cannot separate them from each other. If your body gets tired, your psyche gets tired, and vice versa is also true. Today I will talk about what is considered one of the most important topics in mental disorders, which is Obsessive-compulsive disorder.

**Keywords** Body dysmorphic disorder • Hoarding disorder • Trichotillomania disorder • Skin picking disorder

## Introduction

It is thoughts or actions that the individual repeats continuously until he feels comfortable, and the obsessions and compulsive actions are time consuming and take up an hour or more per day of the individual's life. Logical and in turn affect his thoughts, life and social relations.

There are several types of obsessive-compulsive disorder, and it cannot be limited to a specific type, including:

1. Body dysmorphic disorder.
2. Hoarding disorder.
3. Trichotillomania disorder.
4. Skin picking disorder.
5. Obsessive-compulsive and substance-/medication-related disorders.
6. Obsessive-compulsive and related disorders due to a medical condition.
7. Obsessive-compulsive disorder and other specific related disorders.
8. Obsessive-compulsive and related disorders not specified.

### Body dysmorphic disorder

Preoccupation with one or more perceived defects or abnormalities in physical appearance that cannot be noticed. Appear slightly to others. At some point during the disorder, the individual has performed repetitive behaviors (eg, self-checking in woman B Excessive grooming, skin picking, reassurance-seeking or mental acts (eg, comparing one's appearance to others in response to appearance concerns. Preoccupations cause clinically significant distress or impairment in functioning in social, occupational, or other areas. Other significant performance areas. The disorder is not better explained by concerns about body fat accumulation or the individual's weight. Who meets the diagnostic criteria for an eating disorder.

### Hoarding Disorder

1. Consistent difficulty in disposing or parting with collectibles, regardless of their actual value. This difficulty arises from the perceived need to save things and the distress associated with getting rid of them. Difficulty getting rid of belongings leads to their accumulation, causing crowding and turning living areas into rubble, limiting.
2. Largely from their intended use. If the living areas are tidy, it is only due to the interventions of third parties (for example, family members, cleaners, and authorities). Hoarding causes clinically significant distress or impairment in functioning in social, occupational, or other areas.
3. Other important performance. (Including maintaining a safe environment for self and others). The hoarding is not attributable to another medical condition (eg, traumatic brain injury, cerebrovascular disease.
4. Hoarding is not better explained by symptoms of another mental disorder (eg, obsessions in obsessive-compulsive disorder.
5. Decreased energy in major depressive disorder, delusions in schizophrenia or other psychotic disorders, cognitive deficits in neurocognitive disorder, specific interests in autism spectrum disorder).

### Trichotillomania disorder

Repeated attempts to reduce or stop pulling hair A. repeated pulling of one's hair leading to hair loss. Trichotillomania causes clinically significant distress or impairment of functioning in social, occupational, or other domains other important performance. The disturbance is not better explained by another medical condition (eg, a skin condition). The disturbance is not best explained by symptoms of another mental disorder. Attempts to improve a perceived malfunction or deformity body dysmorphic disorder).

### Skin peeling disorder

1. Repeated attempts to reduce or stop skin picking.
2. Repeated skin picking resulting in skin lesions Dysplasia causes clinically significant distress or impairment of performance in social, occupational, or other C-domains other important performance.
3. Skin stripping is not attributable to the physiological effects of a substance (such as cocaine) or to another medical condition (such as scabies).
4. Skin peeling is not better explained by symptoms of another mental disorder eg, delusions or tactile hallucinations in -E psychotic disorder, attempts to improve a perceived defect or abnormality in body dysmorphic disorder, stereotypedness in

stereotypical movement disorder, or an intention to harm oneself in non-suicidal self-injury).

## Obsessive-compulsive disorder and disorders related to the substance/medicine

Obsessions, compulsions, skin picking, hair pulling, other body-focused repetitive behaviors, or other symptoms of obsessive-compulsive and related disorders dominate the clinical picture.

There is evidence from history, physical examination, or laboratory findings that both (1) and (2) -B are present:

1. The symptoms in Criterion A developed during or immediately following substance intoxication, substance withdrawal, or drug exposure.
2. The accused substance/drug is capable of producing the symptoms in Criterion A. Disturbance is not better explained by OCD and related disorders not caused by C Substance/Medicine. Such evidence of independent obsessive compulsive disorder and related disorders could include the following.

Symptoms precede initiation of substance/medication use, symptoms persist for a significant period of time (eg, about a month) after acute withdrawal or severe intoxication has ended, or there is evidence Another suggests that the existence of OCD and related disorders is independent and not induced by a substance/drug (eg, history of recurrent seizures not related to substances).The disorder does not occur exclusively during the course of a D delirium state. The disturbance causes marked impairment or frustration in social, occupational, or important domains of functioning E other.

## Obsessive-compulsive disorder and other specific related disorders

This classification applies to presentations in which symptoms characteristic of obsessive-compulsive and related disorders 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 category. The Other Specified Obsessive-Compulsive and Related Disorders category is used, in cases where the clinician chooses to communicate a specific reason that the presentation does not meet the specified criteria, for a diagnosis of any of the disorders in the Obsessive- Compulsive and Related Disorders category. This is done by recording "other specified obsessive-compulsive and related disorders" followed by the identified causes (eg body-focused repetitive behavior disorder). Examples of conditions that "other specified" may apply to designate include the following:

1. Body dysmorphic disorder-like disorder with actual deformities: similar to body dysmorphic disorder except that defects or Abnormalities of physical appearance that are clearly noticeable by others (ie more obvious than "slight"). In such cases, preoccupation with these shortcomings is manifestly excessive and causes great degradation or frustration.
2. Body Dysmorphic Disorder-like disorder without repetitive behaviors: Cases meet criteria for dysmorphic disorder Body shape, but the individual did not perform repetitive behaviors or mental actions such as responding to preoccupation with appearance.
3. Body Focused Repetitive Behavior Disorder: It is characterized by body focused repetitive behavior (eg, biting nails, lip biting, cheek chewing) and repeated attempts to reduce or stop the behaviors. These symptoms cause clinically significant distress or impairment in functioning in social, occupational, or other important areas of functioning, and are not better explained by trichotillomania (hair-pulling disorder), skin-picking disorder, stereotypical movement disorder, or non-suicidal self-harm.
4. Obsessive jealousy: It is characterized by a delusional preoccupation with a partner's perceived infidelity. Busyness can lead to Repetitive behaviors or mental actions in response to fears of betrayal that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and are not better explained by another mental disorder such as a delusional disorder, jealousy pattern, or persecutory personality disorder. It is similar to body dysmorphic disorder and is characterized by an excessive fear of physical disfigurement. 6- Kuro: a bout of sudden and intense anxiety that the penis (or the vulva and nipples in females) will retract into the body.
5. Shubo-kyofu - This may lead to death. It is characterized by the fear of having an unpleasant body odor (also called Shubo-kyofu, another form of: Jikoshu-kyofu-7). Olfactory signal syndrome).

## Obsessive-compulsive disorder and related disorders not specified

This classification applies to presentations in which symptoms characteristic of obsessive-compulsive and related disorders that cause clinically significant distress or impairment in functioning in social, occupational, or other areas predominate, but do not meet the full criteria for any of the disorders in the obsessive-compulsive and related disorders category. The obsessive-compulsive and related disorder category not otherwise specified is used in cases where the clinician chooses not to communicate a specific reason that the presentation does not meet the criteria specified for any of the disorders in the obsessive-compulsive and related disorder category. It includes cases in which there is insufficient information to make a more specific diagnosis (for example, in emergency departments).

# Conclusion

There are also many obsessive actions and thoughts that result from individuals, such as obsession with cleaning the house or the place where the individual sits but the individual can only diagnose himself with it by a psychiatrist. The individual must see a psychiatrist and a psychologist to start a treatment plan. Treatment is either pharmacological or cognitive behavioural therapy, or both. This depends on the severity of the condition, symptoms, and the doctor's decision on the type of treatment that the reviewer needs.

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