International Journal of Multidisciplinary Research And Studies

Available online at https://ijmras.com/

INTERNATIONAL JOURNAL OF MULTIDISCIPLINARY RESEARCH AND STUDIES
ISSN: 2640 7272
Volume:04; Issue:01 (2021)

VARIABILITY IN RECURRENT BEHAVIORS ELICITED BY PEOPLE WITH OBSESSIVE-COMPULSIVE DISORDER

Meera Robinson

M.Phil., Roll No.: 141726 Session-2014-15
Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India
E-mail: mrobinson2582@gmail.com

ABSTRACT

The lifetime prevalence of obsessive-compulsive disorder (OCD) ranges between 1% and 4%. 1,2 and demonstrates a considerable amount of diversity in terms of the clinical presentation and comorbidity profile. It has a chronic, unpredictable course that has a substantial impact on individuals and places a strain on carers. The average age at which OCD symptoms appear is bimodal, with the first peak occurring around the age of 11 and the second peak occurring in early adulthood. By the age of around twenty percent of all afflicted individuals had shown symptoms. 5 Obsessive-compulsive isorder that begins in childhood has attracted a lot of attention as an unique phenotype of OCD, having both genetic and developmental foundations. 6 Compulsions including cleaning, checking, ordering, and repeating are typical manifestations of OCD in children. Other common obsessions include contamination, aggression, symmetry, hoarding, and somatic symptoms.

Keyword: Contamination, Aggression, Symmetry, Hoarding, Somatic Symptoms.

INTRODUCTION

In addition to evaluating obsessions and compulsions, the Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS)10 also evaluates auxiliary aspects. represents understanding,

avoidance, a degree of indecisiveness, an exaggerated sense of duty, persistent slowness/disturbance of inertia, and pathological scepticism. Originally, these auxiliary dimensions were included in the scale as "investigatory elements probably related" with OCD. Studies conducted in the years that followed have uncovered connections between these dimensions and other aspects of the condition.

In childhood obsessive compulsive disorder, insight has a positive association with age (better insight with later age at onset), illness severity, avoidance scores, and pervasive slowness/disturbance of inertia scores. Insight also has a positive association with comorbid conditions such as attention deficit hyperactivity disorder.

It has been shown time and time again that greater avoidance ratings are connected with more severe sickness. 14 Symptom dimensions in OCD that have been subjected to factor analysis appear to have varied correlations with auxiliary symptoms. It was found that hoarding was associated with pervasive slowness/disturbance of inertia, indecisiveness, pathological doubting, and inflated sense of responsibility; the obsession dimension (aggressive, sexual, and religious) was found to be associated with pathological doubting and inflated sense of responsibility; contamination/cleaning was found to be associated with avoidance; and symmetry/ordering was found to be associated with indecisiveness. A few of research have also come to the conclusion that ancillary dimensions play a part in functional impairment and that they may modulate the response to cognitive behavioural intervention. There are other reports that contradict the previous ones. A follow-up study of children with OCD that lasted for seven years found that accessory dimensions did not have an effect on the likelihood of remission.

An exaggerated feeling of responsibility is consistent with other obsessive beliefs in adults, which are the basic cognitive schemas that define OCD. The symptomatology of juvenile OCD has been documented in great detail from a variety of locations throughout the world. On the other hand, the auxiliary characteristics of the disorder have not been investigated nearly as thoroughly in terms of their clinical and scientific relevance. The CY-BOCS disease severity evaluation does not take into account avoidance, despite the fact that it is a behaviour that is commonly seen in OCD in children. The purpose of this research was to investigate the auxiliary aspects of OCD in childhood, as well as their relationships with the symptom dimensions and other clinical factors.

The APA Practice Guidelines are not meant to be interpreted in any way, nor are they intended to serve as a benchmark for medical treatment. The standards of medical care are

Meera Robionson*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: mrobinson2582@gmail.com

established based on an analysis of all of the clinical data that is available for a specific patient. These standards are susceptible to change as scientific knowledge and technology continue to grow and as practise patterns continue to develop. Only recommendations ought to be thought of as being contained within these limitations of practise. Adherence to them does not guarantee a successful outcome for every individual, nor should they be interpreted as including all appropriate methods of care or excluding other acceptable methods of care that aim to achieve the same results. Neither should they be interpreted as excluding other acceptable methods of care that aim to achieve the same results. In consideration of the clinical facts provided by the patient as well as the many diagnostic and therapeutic choices that are accessible, the psychiatrist is the one who must make the definitive decision on a certain clinical procedure or treatment plan. Psychiatrists who are currently engaged in therapeutic work were responsible for the development of this practise guideline.

In addition, some of the contributors are primarily engaged in academic activities such as research or other projects. It is likely that some of the authors, including members of the work group and reviewers, have received revenue connected to the therapies that are covered in this guideline as a result of such actions. There are a variety of methods that have been put into place to help reduce the likelihood that suggestions may be prejudiced as a result of competing interests. The members of the work group are chosen for their professionalism and honesty in the selection process. The Steering Committee on Practice Guidelines and the work group have requested that any member of the work group or reviewer who may have a possible conflict of interest that may prejudice (or appear to affect) his or her work report this information. Iterative guideline draughts are subjected to evaluation by the Steering Committee, as well as other experts, affiliated organisations, APA members, and the APA Assembly and Board of Trustees; important updates address or incorporate the concerns of these many reviewers. No for-profit company or business is providing funding for the American Psychological Association's (APA) practise standards project. The "APA Guideline Development Process" paper that is offered by the American Psychiatric Association's Department of Quality Improvement and Psychiatric Services provides further information regarding the procedures that are in place to reduce bias. The approval of this practise guideline came in October of 2006, and it was released to the public in July of 2007.

Meera Robionson*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: mrobinson2582@gmail.com

PSYCHIATRIC MANAGEMENT

In clinical practise, obsessive-compulsive disorder, sometimes known as OCD, is almost always a chronic condition that follows a path that is both waxing and waning. When OCD symptoms interfere with functioning or create severe discomfort, treatment is recommended . Psychiatric care consists of a variety of therapeutic acts that may be delivered to all patients with OCD over the duration of their condition at an intensity that is compatible with the individual patient's requirements, capacities, and desires. These actions may include: It is essential to coordinate the patient's treatment with the doctors who are treating any co-existing medical issues, as well as with any other clinicians and social organisations, including schools and vocational rehabilitation programmes. When a patient's OCD is severe enough to be considered disabling, the patient's psychiatrist may be required to write letters on the patient's behalf to government agencies that control access to disability income, publicly financed health care, or government-supported housing; or to tax authorities, courts, schools, or employers. Patients suffering from OCD who are also parents of small children might desire some guidance on the hereditary risk of OCD. It is vital for doctors to communicate to such patients that the data that are now available show an elevated but slight risk of OCD in the offspring of afflicted persons; patients who desire additional information may be directed to a genetic counsellor.

ESTABLISHING A THERAPEUTIC ALLIANCE

It is critical to not only form but also sustain a solid therapeutic alliance in order to allow for collaborative treatment planning and delivery, which ultimately results in improved outcomes . Steps that may be taken toward this goal include adapting one's method of communication to the patient's capabilities and requirements, providing an explanation of symptoms that can be understood, and acting in a manner that is both reassuring and encouraging. Due to the excessive scepticism that is characteristic of OCD, it may be necessary to take unique techniques while forming the alliance. These may include giving the patient more time to deliberate about treatment options and repeating explanations (for a predetermined number of times). When developing a therapeutic alliance with the patient, the psychiatrist needs to take into account not just how the patient reacts and behaves toward him or her, but also the patient's desires and expectations for treatment.

Meera Robionson*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: mrobinson2582@gmail.com

ASSESSING THE PATIENT'S SYMPTOMS

In assessing the patient's symptoms with the aim of establishing a diagnosis using DSM-IV-TR criteria, it is important to differentiate the obsessions, compulsions, and rituals of OCD from similar symptoms found in other disorders, including depressive ruminations, the worries of generalized anxiety disorder, the intrusive thoughts and images of posttraumatic stress disorder, and schizophrenic and manic delusions.

ENHANCING THE SAFETY OF THE PATIENT AND OTHERS

The patient's safety, as well as the safety of others, should be evaluated by the psychiatrist. This involves determining whether or not the patient is at risk for self-harm or suicide, given that people with OCD on their own or with a lifetime history of any co-occurring condition have a higher attempted suicide rate than people in the general community do. Even though patients with OCD have not been observed acting on aggressive impulses or thoughts, and even though patients with OCD rarely resort to violence when others get in the way of them performing their compulsive rituals, it is still important to inquire about patients' histories of aggressive behaviour in the past. Patients with OCD who are afraid of losing control may resort to intensive avoidance routines in an attempt to keep their symptoms under control. The psychiatrist has to be aware of the fact that people who suffer from OCD are not immune to co-occurring illnesses, and that these diseases might increase the probability that a patient would engage in suicidal or violent conduct. It is imperative, in situations when such co-occurring illnesses are prevalent, to organise therapies that will improve the patient's and the surrounding community's level of safety. Because OCD symptoms can also make it difficult to parent, the clinician may need to collaborate with the patient's other parent or with social service organisations in order to lessen the impact that the patient's OCD symptoms have on the patient's children.

COMPLETING THE PSYCHIATRIC ASSESSMENT

When the psychiatrist is through with the mental examination, they will often take into consideration all of the components of the conventional medical evaluation. In the context of co-occurring diseases, the psychiatrist should pay special attention to evidence of depression, whether it be from the past or the present, due to the frequency with which depression is associated with suicidal ideas and behaviours. In light of the potential for anti-OCD drugs to precipitate hypomania or mania, it is essential to investigate the presence of a concurrent

Meera Robionson*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: mrobinson2582@gmail.com

bipolar illness as well as the presence of a family history of the condition. OCD patients frequently suffer from other anxiety disorders in addition to tic problems, which can make treatment planning more challenging. Other illnesses, such as impulse-control disorders, anorexia nervosa, bulimia nervosa, alcohol use disorders, and attention deficit hyperactivity disorder, are also known to be rather frequent and have the potential to make treatment planning more difficult. The patient's history of panic episodes, mood fluctuations, substance misuse or dependency, and other similar experiences are also significant. It is essential to keep a record of the patient's progression of symptoms and treatment history, which should include any psychiatric hospitalisations as well as any trials of medications (including specifics on treatment adequacy, dose, duration, response, and side effects), as well as any psychotherapies.

ESTABLISHING GOALS FOR TREATMENT

Clinical healing and complete remission, if they do occur, take a significant amount of time. Therefore, minimising the frequency and intensity of symptoms, enhancing the patient's functioning, and assisting the patient in improving his or her quality of life are continuous therapy goals . Helping the patient develop coping strategies for stressors and educating the patient as well as the patient's family about the disorder and its treatment are also treatment goals. These goals include enhancing the patient's ability to cooperate with care despite the frightening cognitions generated by OCD, minimising any adverse effects of treatment (such as the side effects of medication), and helping the patient develop coping strategies for stressors.

ENHANCING TREATMENT ADHERENCE

The adherence to therapy can be improved if the psychiatrist takes into account aspects that are associated with the patient, the disease, the physician, the connection between the patient and the physician, the treatment, as well as the social or environmental context. Providing education to the patient and their family has the potential to improve adherence . This is due to the fact that the patient's views about the nature of the illness and its treatments will impact adherence. The Obsessive Compulsive Foundation makes available educational resources and facilitates access to support groups, both of which are beneficial to a significant number of OCD sufferers (www.ocfoundation.org). Motivational interviewing or other psychosocial therapies designed to promote readiness for change may be beneficial when a patient does not have adequate motivation to participate successfully in treatment. Because the medications

Meera Robionson*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: mrobinson2582@gmail.com

that are used to treat OCD can cause side effects, particularly when they are given in high doses, adherence can be improved by informing the patient about any likely side effects, responding quickly to concerns about side effects, and scheduling follow-up appointments shortly after starting or changing medications. When discussing cognitive-behavioral therapy, or CBT, it is helpful to inform clients that treatment entails facing dreaded ideas and events, however at an acceptable rate. It is possible that logistical concerns, such as the expense of treatment, the availability of insurance coverage, and transportation, may need to be addressed. When a patient with OCD refuses treatment or prematurely stops treatment, the clinician may want to recommend that the patient's family members and other people whose lives have been negatively affected by the OCD seek therapy to help develop strategies to mitigate the effect that the patient's OCD has on their lives and to encourage the patient to obtain treatment.

REVIEW OF LITRERATURE

Noriko Horii-Hayashi (2019) Obsessive-compulsive disorder, sometimes known as OCD, is a form of mental illness that is characterised by obsessive thoughts as well as compulsive behaviours. These perspectives are not properly supported by neurological data, despite the fact that certain theories claim that people who suffer from OCD have cognitive biases and disordered motivation about a prospective danger. Activation of hypothalamic perifornical (PeF) urocortin-3 (UCN3) neurons in mice causes the animals to inspect and bury unfamiliar things in an excessive and repeated manner. These neurons are implicated in defensive reactions to a possible threat. In this work, we tested the notion that mice with activated PeF UCN3 neurons may serve as a model for OCD. We did this by examining the mice's behaviour.

Chemogenetically activating PeF UCN3 neurons in Ucn3-Cre mice with clozapine-N oxide (CNO) resulted in PeF UCN3 neuronal activity. OCD-like behaviours were assessed by looking for things like excessive reactions to a new object, repeated or stereotypical behaviours in the homecage, and activities like burying marbles. On these behaviours, the effects of medicines that are currently used in clinical practise for the treatment of OCD were analysed. Using c-Fos immunolabeling, the effect of CNO on brain activity in the cortico-striatothalamo-cortical loop, which is considered to be an OCD circuit, was analysed.

Franklin M. (2019) The obsessive-compulsive disorder, sometimes known as OCD, is a serious illness that can manifest itself in a variety of ways. Exposure and ritual prevention

Meera Robionson*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: mrobinson2582@gmail.com

(EX/RP) is the cognitive-behavioral treatment for obsessive-compulsive disorder (OCD) that has the best scientific evidence at this time; nonetheless, clinical impression and some empirical data show that specific OCD symptoms are more receptive to treatment than others. Methods: Previous work that identified symptom dimensions within OCD is addressed in this article. This work includes epidemiological data, factor analytic investigations, and biological findings. The aspects of contamination and cleansing, uncertainty about doing damage and checking, symmetry and ordering, and inappropriate ideas and mental routines are the ones that can be consistently detected the most. The phenomenology of each of these subtypes is discussed, and a summary of the relevant research literature is provided. Particular attention is paid to the distinct influences that EX/RP and its variations exert on each of these key symptom dimensions.

Núria de la Osa (2019) It is known very little about the combination of oppositionality and obsessive-compulsive disorders (OCP) in community children and how it impacts their development until puberty to prevent any dysfunctions in their later lives. The co-development of oppositional defiant dimensions and oppositional control problems (OCP) is being studied in a group of 563 children (49.7% of whom are female) ranging in age from 6 to 13 years old. These children are evaluated yearly using measures that are answered by their parents and teachers. We used a 4-class model based on a Latent Class Growth Analysis for three parallel processes (irritability, defiant, and OCP) since it exhibited satisfactory fitting indices. This model was based on our findings. Children in Class 1 (n = 349, 62.0%) had low scores on all of the assessments. Class 2 consisted of children who had a high OCP but a low level of irritation and rebellious behaviour (n = 53, 9.4%). Children that grouped together in Class 3 (n = 108, 19.2%) had significant levels of irritation and defiance while having low OCP. Class 4 showed clustering of comorbid irritability, rebellious behaviour, and OCP features (n = 53, 9.4%). Throughout the course of development, each class displayed a unique set of clinical features. The developmental co-occurrence of irritability and rebellious behaviours in addition to obsessive-compulsive behaviours is common and adds severity during development in regards to comorbidity, peer issues, challenges with executive functioning, and day-to-day functioning. When oppositional difficulties and OCP are combined, the identification of various classes may be instructive for the purpose of preventing developmental dysfunctions and promoting healthy adjustment throughout the developmental process.

Meera Robionson*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: mrobinson2582@gmail.com

RESEARCH METHODOLOGY

In the DSM-IV-TR, the basic characteristics of OCD are described as "recurrent obsessions or compulsions (Criterion A) that are severe enough to be time consuming (i.e., they require more than one hour a day) or produce noticeable distress or major impairment (Criterion C)" (1, pp. 456–457). The intrusive, persistent, and unwelcome thoughts, urges, or pictures that constitute an obsession are the source of a significant amount of worry or discomfort. Compulsions are defined as behaviours, either physical or mental, that the patient feels compelled to perform in the hopes that by doing so, they may magically prevent some feared occurrence, reverse some idea, or reduce worry or discomfort. Acts that are carried out compulsively are also referred to as rituals. Rituals are characterised by recurrence, excess, and, most of the time, adherence to rules or a rigorous approach. Obsessions might develop for no apparent reason, or they can be triggered by a dreaded sensation or occurrence in the environment. Mental compulsions include praying, counting, and going over old material.

APA PRACTICE GUIDELINES

The patient actively initiates activities, discussions, or lists with the intention of feeling safer, lowering anxiety or suffering, or achieving a combination of these goals. Fears of becoming contaminated or spreading contamination, accidentally or purposefully harming others, making a significant mistake, committing a religious offence or moral infraction, contracting a disease, and being considered homosexual or committing homosexual or pedophilic acts are the most common obsessional themes. Other common obsessional themes include fears of making a significant mistake, making a significant mistake, accidentally or purposefully harming others, and making a significant mistake.

The presence of hoarding as a sign of OCD is typically not frightening, despite the fact that it may cause remorse. People who suffer from OCD may also be obsessed with things like symmetry or orderliness, fortunate or unlucky numbers or colours, the desire to know something or remember it, heterosexual actions, or their own physiological condition. Obsessions are sometimes accompanied by a sense of ambiguity, doubt, or incompleteness that drives repetitious thinking or activity. Additionally, obsessions are frequently characterised by an exaggerated estimation of risk, an increased sense of duty, or a demand for clarity or perfection. Psychiatric management of OCD is indicated when symp- toms interfere with functioning or cause significant dis- tress. Although transient

Meera Robionson*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: mrobinson2582@gmail.com

OCD is found in community surveys, OCD seen in clinical practice is usually a chronic illness with a waxing and waning course. With appropriate treatment, OCD symptoms usually improve over weeks or months and may become mild or even subside into remission over months or years. Thus, treatment planning and psychiatric management will be iterative processes adapted to the patient's current status and response to previous interventions.

Psychiatric management encompasses a broad collec- tion of professional actions and interventions designed to benefit the patient. These actions and interventions in- clude providing the following:

- Pharmacotherapy and psychotherapy in the appropriate setting, as indicated by patient preference and clinical judgement;
- Guidance to the patient and involved family members about educational materials that are available in published form and on the web (see Appendix); and
- Information about local support groups in the patient's area (see Appendix).

Throughout the course of the disease, psychiatric treatment should be administered at a level of intensity that is consistent with the patient's needs, abilities, and preferences. This should be the case regardless of the severity of the condition. In the following, a more in-depth discussion of the components of psychiatric treatment that are applicable across the phases of disease are provided:

DATA ANALYSIS

SPECIFIC CLINICAL FEATURES INFLUENCING THE TREATMENT PLAN

A good number of the clinical characteristics that will have an effect on the treatment plan have been discussed in the preceding paragraphs in relation to the selection of a treatment setting and the approaches for promoting adherence. Detailed explanations of the other features follow below.

PSYCHIATRIC FEATURES

The doctor should take into consideration the patient's reaction to previous therapies, including the advantages and side effects, as well as the patient's motivation and capacity to adhere to pharmacotherapy and psychotherapy when making treatment recommendations for adults. It has been shown that educational activities are a typical component of therapy and that they boost treatment motivation. Concurrent interventions, such as family therapy, may

Meera Robionson*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: mrobinson2582@gmail.com

be necessary if a patient's living environment is unstable or stressful, which reduces the likelihood that treatment will be successful.

It is helpful to evaluate the level of insight possessed by the patient since this factor might have an effect on the patient's desire to participate with treatment. Quantitative measurements may be obtained through the use of the Brown Assessment of Beliefs Scale (204) and the Overvalued Ideas Scale (OVIS) . Poor insight is linked to a poorer response to selective serotonin reuptake inhibitors in the majority of studies but not all, as well as a poorer response to cognitive behavioural therapy in certain research but not others.

If a patient's primary or sole OCD symptom is hoarding, there is a decreased likelihood that they will benefit from medication, cognitive behavioural therapy, or a combination of the two. (i.e., acquir- ing or accumulating items such as newspapers, magazines, books, packaging, old clothing, notes, and lists that are beyond reasonable need or of little objective value).

Patients who exhibit these individuals' symptom patterns typically exhibit less insight, less anguish, and, as a result, less drive for change, which might make them less receptive to therapy than patients who exhibit other patterns of symptoms. However, a recent research indicated that individuals with OCD who hoard reacted just as favourably to medication as patients with OCD who exhibited other forms of symptoms. There is a possibility that there are differences in the underlying neurobiology or OCD-related genetics of hoarding patients as compared to people who do not hoard. There have been descriptions of specific therapy programmes that achieve a benefit with hoarding patients. However, these programmes have not been evaluated in controlled studies. An informative website (San Francisco Bay Area Resource & Internet Guide for Extreme Hoarding Behavior, Clutterers Syndrome, or Pack Rat Syndrome) is provided in the appendix).

CHRONIC MOTOR TICS

It has been demonstrated that the presence of co-occurring chronic motor tics in the absence of Tourette syndrome reduces the likelihood of having Tourette syndrome. probability of reaction to fluvoxamine, but not to clomipramine (no response was seen. Patients diagnosed with OCD who have co-occurring tics and have not responded to treatment with an SRI may benefit from the addition of an antipsychotic medication. Despite the fact that tic development or worsening during SSRI therapy has been recorded in a few rare cases, OCD patients who also suffer from co-occurring motor tics

Meera Robionson*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: mrobinson2582@gmail.com

should not be denied access to SSRI treatment trials.

TOURETTE'S DISORDER

OCD co-occurring with Tourette's disorder can be treated with SRIs, which usually have little effect, either positive or negative, on the tic symptoms. When the OCD fails to respond after one or two adequate SRI trials, adding a first-generation (typical) or second-generation (atypical) antipsychotic drug in a low to modest dose may ameliorate both disorders ().

MAJOR DEPRESSION

The presence of significant depression in conjunction with OCD does not have a negative impact on the responsiveness to SRI treatment. When a patient's severe depression reacts poorly to treatment while their obsessive compulsive disorder performs well, the patient has various options, none of which have been well researched in big double-blind trials. As a consequence of this, it is not unreasonable to use the treatment methods described in the APA's Practice Guideline for the Treatment of Patients With Major Depressive Disorder. These include the use of psychotherapies that are effective in treating depression (such as interpersonal psychotherapy, cognitive behavioural therapy, or short-term psychodynamic therapy), increasing the dose of an SRI, adding an antidepressant from another class, adding an augmenting agent, or, in patients with severe, treatment-resistant, or suicidal depression, utilising electroconvulsive therapy (ECT). Co-occurring major depression has been related with a worse OCD result in several clinical trials of cognitive behavioural therapy , but not all . CBT is obviously impeded when severe depression is present and present. As a result, the use of antidepressant medication, and specifically SRIs, to treat co-occurring severe depression prior to or during a trial of CBT may be beneficial.

BIPOLAR DISORDER

Before beginning therapy with agents, such as SRIs, that may induce or aggravate hypomania or mania, the treatment of individuals who have both OCD and bipolar disorder should involve steps to establish mood stability. This should be done before beginning treatment with drugs. It is possible that a combination of medications, such as lithium, anticonvulsants, and second-generation antipsychotic medicines, will be necessary in order to stabilise the symptoms of bipolar illness. It would suggest that SSRIs are less likely than clomipramine to bring on episodes of hypomania or mania in individuals with bipolar disorder and OCD. When clomipramine, fluoxetine,

Meera Robionson*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: mrobinson2582@gmail.com

fluvoxamine, paroxetine, or sertraline are contemplated for usage in conjunction with the aforementioned medications, one should give careful consideration to the possibility of adverse drug interactions occurring.

It indicates that OCD patients who also have bipolar illness have a much higher incidence of the kind of OCD known as episodic OCD, which is characterised by periods of drastically varied symptom intensity irrespective of OCD treatment. Therefore, a history of episodic OCD should raise the suspicion of the psychiatrist that the patient may also be suffering from co-occurring bipolar illness. Patients with episodic OCD tend to be more prone to suffer from alcohol addiction or dependency, panic disorder, and agoraphobia, all of which will require therapy in addition to their OCD treatment. This may be due to the presence of co-occurring bipolar illness in these patients.

CONCLUSION

Even though the symptoms of OCD can be alleviated by the therapy techniques that are now in use, greater study is required to improve upon the therapies that are currently available and to discover new therapeutic choices. To be more precise, research has to be done to evaluate whether or if alterations to treatment protocols can enhance the percentage of patients who react to treatment as well as the magnitude, speed, and longevity of the response. Studies might establish, for instance, whether larger dosages of SRIs or more rapid titration resulted in a faster therapeutic response and more symptom alleviation. A number of drugs (such as mirtazapine, pindolol, stimulants, opiate-receptor agonists, glutamate-modulating compounds, inositol, ondansetron, and several of the antidepressants) have been shown to be effective in the treatment of depression. anticonvulsants and lithium, for example) have demonstrated some degree of success in preliminary studies either on their own or as augmentation strategies; nonetheless, these medicines and associated techniques require more study in larger randomised trials.

REFERENCE

1. Antony MM, McCabe RE: 10 Simple Solutions to Panic: How to Overcome Panic Attacks, Calm Phys- ical Symptoms, and Reclaim Your Life. Oakland, CA, New Harbinger Publications, 2004.
2. Craske MG, Barlow DH: Mastery of Your Anxiety and Worry: Client Workbook, 2nd ed. New York, Ox-ford University Press, 2006.
3. Pollard CA, Zuercher-White E: The Agoraphobia Workbook: A Comprehensive

Meera Robionson*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: mrobinson2582@gmail.com

Program to End Your Fear of Symptom Attacks. Oakland, CA, New Harbinger Publications, 2003.

4. Rachman S, De Silva P: Panic Disorder: The Facts, 2nd ed. New York, Oxford University Press, 2004.
5. Hollander E, Bakalar N: Coping With Social Anxiety: The Definitive Guide to Effective Treatment Options. New York, Henry Holt, 2005.
6. Stein MB, Walker JR: Triumph Over Shyness: Con- quering Shyness and Social Anxiety. Columbus, OH, McGraw Hill, 2002.
7. Armstrong K, Best S, Domenci P: Courage After Fire: Coping Strategies for Returning Soldiers and Their Families. Berkeley, CA, Ulysses Press, 2005.
8. Marks IM: Living With Fear: Understanding and Coping With Anxiety, 2nd ed. New York, McGraw- Hill, 2002.
9. Ghaziuddin M: Mental Health Aspects of Autism and Asperger Syndrome. London, UK, Jessica Kingsley Publishers, 2005.
10. Volkmar FR, Paul R, Klin A, Cohen DJ: Handbook of Autism and Pervasive Developmental Disorders, 2 Vols. New York, John Wiley & Sons, 2005.
11. Sohn A, Grayson C: Parenting Your Asperger's Child: Individualized Solutions for Teaching Your Child Practical Skills. New York, Perigee, 2005.
12. DuCharme RW, Gullotta TP: Asperger Syndrome: A Guide for Professionals and Families. New York, Springer, 2003.
13. Claiborn J, Pedrick C: The BDD Workbook: Over- coming Body Dysmorphic Disorder and End Body Obsessions. Oakland, CA, New Harbinger Publica- tions, 2002.
14. Phillips KA: The Broken Mirror: Understanding and Treating Body Dysmorphic Disorder. New York, Oxford University Press, 2005.
15. Pope HG, Phillips KA, Olivardia R: The Adonis Complex: How to Identify, Treat and Prevent Body Obsession in Men and Boys. New York, Touchstone, 2002.
16. Wilhelm S: Feeling Good About the Way You Look: A Program for Overcoming Body Image Problems. New York, Guilford, 2006.

Meera Robionson*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: mrobinson2582@gmail.com