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Obsessive-Compulsive and Related Disorders

Slides: B Chow
Edits: L Jia

Updated 2021

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Obsessive-Compulsive & Related Disorders

- OCD
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania
- Excoriation Disorder
- Substance/Medication-Induced OC&RD
- Obsessive-Compulsive & Related Disorder due to AMC
- Other Specified OC&RD
- Unspecified OC&RD

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Obsessive-Compulsive Disorder

OCD – Diagnostic Criteria

A. Obsessions, compulsions, or both:
   1. Obsessions (BOTH)
      - **Recurrent** thoughts/urges/images, **intrusive + unwanted**, **distressing**
      - **Attempts to supress**, ignore or neutralize

   2. Compulsions (BOTH)
      - **Repetitive behaviors, feels driven** to do**,** due to **obsession or rules**
      - Aimed to prevent **anxiety/distress**, but **not connected or excessive**

B. **Time-consuming**, or cause **sig distress/impairment**

C. Not due to substance or AMC

D. Not better explained by AMD

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OCD – Diagnostic Specifiers

- *Specify if:*
  - **With good or fair insight:** recognizes definitely/probably not true
  - **With poor insight:** thinks probably true
  - **With absent insight/delusional beliefs:** convinced beliefs are true

- *Specify if:*
  - **Tic-related:** current OR past hx of tic disorder

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OCD – Diagnostic Specifiers

- Dysfunctional beliefs
  - Inflated **sense of responsibility**, tendency to overestimate threat
  - Perfectionism, intolerance of uncertainty
  - Over-importance of thoughts, need to control thoughts

- Degree of insight → accuracy of beliefs, can vary over course
  - **Good/fair insight → many**
  - Poor insight → **some**
  - Absent insight/delusional beliefs → **4% or less**
  - **Poorer insight → worse long-term outcome**

- Tic disorders → 30% of OCD have lifetime tic disorder
  - Most common in **MALES** with childhood-onset OCD
  - **OCD with tic disorder differs** in sx, comorbidity, course, family transmission

OCD – Diagnostic Features

- Obsessions
  - Repetitive, persistent **thoughts, images, urges**
    - Contamination, violent scenes, stabbing someone
  - **NOT pleasurable**, not experienced as voluntary
  - **Intrusive, unwanted**
  - Cause **marked distress or anxiety**

- Compulsions
  - Repetitive **behaviors, rituals, mental acts**
    - Washing, checking, counting, repeating words silently
  - **Feels driven** to perform
  - In response to **obsession**, or according to **rigid rules**
    - Washing rituals, repeating until it feels just right
  - Aimed to **reduce distress**, **prevent feared event**
  - **NOT connected** in realistic way, or **clearly excessive**
  - **NOT done for pleasure** (but may experience relief)

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OCD – Diagnostic Features

- Most individuals have both obsessions + compulsions
  - Must be **time-consuming** (>1 hr per day)
  - Or cause **significant distress/impairment**
  - (occasional intrusive thoughts/repetitive behaviors common in gen pop)

- Frequency + severity varies
  - Mild (1-3 hrs per day) → severe (constant)

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OCD – Associated Features

- Common themes (obsessions → compulsions)
  - **Cleaning:** contamination → cleaning
  - **Symmetry:** symmetry → repeating, ordering, counting
  - **Forbidden/taboo:** aggressive, sexual, religious → related compulsions
  - **Harm:** fears of harm to self/others → checking, hoarding
  - Occur **across cultures, consistent over time, often multiple themes**

- Range of affective responses
  - Marked anxiety, recurrent panic attacks
  - Strong feelings of **disgust**
  - Distressing sense of "incompleteness" or uneasiness until "just right"

- **Common avoidance** of triggers (people, places, things)
  - Feared contaminants → avoid pubic situations/places
  - Fear of harm → avoid social interactions

OCD – Prevalence

- 12-month prevalence = **1.2%** (US), **1.1 – 1.8%** (international)
  - **Childhood** → **MALES** > F
  - **Adulthood** → **FEMALES** > M

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OCD – Development & Course

- Onset
  - Mean age at onset = **age 19.5**
    - 25% cases start by **age 14** → rare after age 35
  - **Earlier onset in MALES** → 25% males onset before age 10
  - Typically **gradual onset**

- Untreated course
  - Chronic, waxing/waning symptoms
    - Some have **episodic course** → minority have **deteriorating course**
  - **Low remission rates in adults** (20% after 40 years)
    - Up to 40% remission by adulthood if **onset in C&A**
  - May be complicated by comorbidities

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OCD – Development & Course

- In children
  - **Compulsions more easily observed** + diagnosed (vs obsessions)
    - Most children have both
  - Pattern of symptoms **more variable** (vs adults)
  - Content differences likely reflect **different developmental stages**

OCD – Risk & Prognostic Factors

- Temperamental
  - Greater **internalizing symptoms**
  - Higher **negative emotionality**
  - Higher **behavioral inhibition** (in childhood)

- Environmental
  - Childhood abuse (physical/sexual)
  - Stressful/traumatic events
  - Sudden onset OCD in children assoc with **infectious agents,** **postinfectious autoimmune syndrome**

- Genetic & Physiological
  - **2-3x rate** among **1º relatives** of adults with OCD
  - **10x rate** among **1º relatives** of OCD onset in C&A
  - Familial transmission partly due to **genetics**
  - Dysfunction in **orbitofrontal cortex, ACC, striatum**

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OCD – Culture-Related Issues

- Similar across cultures
  - Gender ratio, age at onset, comorbidities
  - Similar themes
  - Regional/cultural variation exists

OCD – Gender-Related Issues

Males	Females
• **Earlier onset** • More likely comorbid **tic disorders** • More likely **forbidden, symmetry** themes	• More likely **cleaning** theme • Can affect **mother-infant relationships postpartum**

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OCD – Suicide Risk

- **50% have suicidal thoughts** at some point
- **25% make suicide attempt**

- Incr risk with comorbid **MDD**

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OCD – Functional Consequences

- Reduced quality of life, high levels of impairment
  - Assoc with symptom severity
  - Specific symptoms can create specific obstacles
    - May interfere with its own treatment
    - Avoidance can severity restrict functioning
  - If C&A onset → may experience **developmental difficulties**
    - Avoid socializing, struggle living independently

- Potential consequences
  - School + health consequences
  - **Few sig relationships** outside family
  - Lack of **autonomy/financial independence**
  - May try to **impose rules** on family
  - May lead to family dysfunction

OCD – Differential Diagnosis

- Anxiety disorders
  - GAD → real-life concerns (vs odd, irrational, seemingly magical)
  - Specific phobia → more circumscribed, no rituals
  - SAD → limited to social interactions
- Major depressive disorder
  - MDD → ruminations, mood-congruent, not as intrusive, no compulsions
- Eating disorders → limited to food/weight
- Other OC&R disorders
  - **BDD** → limited to physical appearance
  - **Trichotillomania** → limited to hair pulling, no obsessions
  - **Hoarding** → focused on accumulation/discarding

OCD – Differential Diagnosis

- Tic disorder, stereotyped movements → can dx BOTH
  - Tic → sudden, rapid, recurrent, nonrhythmic motor movement/vocalization
  - Stereotyped movement → repetitive, driven, non-functional motor behavior
  - Typically less complex (vs compulsions), not to neutralize obsessions
  - **Premonitory sensory urges typically precede tics**

- Psychotic disorders
  - May have poor insight/delusional OCD beliefs
  - No other features (hallucinations, formal thought disorder)

- Other compulsive-like behaviors
  - Paraphilias, gambling, substance use → **derives PLEASURE**
  - May only wish to resist due to **deleterious consequences**

- OCPD → can dx BOTH
  - Enduring, pervasive maladaptive pattern → perfectionism, rigid control

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OCD – Comorbidity

- Comorbidity common
  - Lifetime anxiety disorder = **76%** → OCD usually AFTER anxiety/PTSD (except separation anxiety)
  - Lifetime mood disorder = **63%**
  - Lifetime **MDD = 41%** → OCD usually BEFORE depressive disorder
  - Comorbid OCPD = **23-32%**

- Lifetime tic disorder = **30%**
  - Most common in **MALES, childhood onset OCD**
  - Different OCD sx, comorbidity, course, familial transmission
  - Childhood triad → **OCD, tic disorder, ADHD**

- Disorders that are more frequent if OCD present
  - OC&RD → BDD, trichotillomania, excoriation disorder
  - Some assoc impulsivity disorders (ODD)

OCD – Comorbidity

- <u>OCD more common if certain disorders</u>
  - Schizophrenia, schizoaffective disorder → **12% have OCD**
  - Bipolar disorder
  - AN/BN
  - Tourette's' disorder

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Body Dysmorphic Disorder

Body Dysmorphic Disorder – Diagnostic Criteria

A. Preoccupation with 1+ **perceived defects in physical appearance**, not observable or slight to others

B. At one point, performed **repetitive behaviors or mental acts** in response to appearance concerns

C. Significant distress or impairment

D. Not better explained by eating disorder

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Body Dysmorphic Disorder – Diagnostic Specifiers

- *Specify if:*
  - **With muscle dysmorphia:** insufficiently muscular, build too small
    - (specifier used, even if preoccupied with other areas)

- *Specify if:*
  - **With good or fair insight:** definitely/probably not true
  - **With poor insight:** probably true
  - **With absent insight/delusional beliefs:** completely convinced true

Body Dysmorphic Disorder – Diagnostic Features

- A) Perceived defects/flaws in physical appearance
  - Flaws not observable or appear only slight to others
  - Believe they look ugly, unattractive, abnormal, deformed
  - Can focus on one or many body areas
    - Most common → **skin, hair, nose**
    - Eyes, teeth, weight, stomach, breasts, legs, face, genitals, etc.
    - **Perceived asymmetry**
  - Preoccupations → **intrusive, unwanted, time-consuming**
    - **Difficult to resist/control**

Body Dysmorphic Disorder – Diagnostic Features

- B) Repetitive behaviors or mental acts
  - In response to preoccupation → **NO pleasure**, may incr anxiety/dysphoria
    - Typically time-consuming, difficult to resist/control

  - **Comparing** to others, checking mirrors/reflections, direct examining
  - Excessive **grooming** (combing, styling, shaving, plucking, pulling hair)
  - **Camouflaging** (repeated makeup, covering disliked areas), tanning
  - Seeking **reassurance**, excessive exercise, cosmetic procedures
  - **Repeatedly changing** clothes, compulsive shopping (beauty products)
  - Compulsive **skin picking** → to improve perceived skin defects

Body Dysmorphic Disorder – Diagnostic Features

- Muscle dysmorphia → almost exclusively **MALE**
  - Build too small, insufficiently lean or muscular
    - May actually be normal looking or very muscular
  - May also be preoccupied with other areas
  - Majority **diet, exercise, lift weights excessively** (even if bodily damage)
  - May use **anabolic-androgenic steroids**

- "Body dysmorphic disorder by proxy"
  - Preoccupied with physical defects in another person

- Insight varies
  - Poor insight → on average
  - **Delusional** → **33% or more**
    - Greater morbidity, HIGHER suicidality

Body Dysmorphic Disorder – Associated Features

- Associated psychiatric symptoms
  - **Ideas/delusions of references** (others taking special notice or mocking)
  - **Anxiety** (high levels, social anxiety, social avoidance)
  - **Depressive** (low mood, low self-esteem, low extroversion)
  - **Negative affectivity** (neuroticism, perfectionism)
  - Shame, reluctance to share concerns

- Majority receive cosmetic treatment
  - **Dermatological tx/surgery** → MOST COMMON
    - Dental, electrolysis, may perform surgery on self
    - BDD **responds POORLY** to such tx → may make worse
  - May take legal action towards clinician

- Cognitive changes
  - **Executive dysfunction, visual processing abnormalities**
    - Analyzing details (vs holistic aspects)
    - Negative/threatening interpretations of facial expressions, ambiguity

Body Dysmorphic Disorder – Prevalence

- Point prevalence (US) = **2.4%** (M 2.2%, F 2.5%)
  - Outside US → **1.7 – 1.8%** (similar gender distribution)

- Among particular clinical populations
  - Dermatology → 9-15%
  - US cosmetic surgery → 7-8%
  - Intl cosmetic surgery → 3-16%
  - Oral/maxillofacial → 10%
  - Adult orthodontics → 8%

Body Dysmorphic Disorder – Development & Course

- Onset
  - Mean age at onset = **age 16-17** (66% before age 18)
    - Median age at onset = age 15
    - MOST common age at onset = **age 12-13**
  - Subclinical sx on average before age 12-13
    - Usually **gradual evolution** to full disorder (can be abrupt)

- Onset BEFORE age 18
  - More likely to **attempt SUICIDE**
  - More **comorbidity**
  - More **gradual onset**

- Clinical features mostly similar in children, adolescents, adults
  - Little known about BDD in elderly (does occur)

Body Dysmorphic Disorder – Risk & Prognostic Factors

- Environmental
  - High rates of **childhood neglect + abuse**
- Genetic & Physiological
  - High prevalence of BDD in **1º relatives with OCD**

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Body Dysmorphic Disorder – Culture-Related Issues

- Similarities across races/culture
  - Cultural values/preferences influence symptom content

- Japan
  - “tai jin kyofusho” → “shubo-kyofu” (phobia of deformed body)

Body Dysmorphic Disorder – Gender-Related Issues

- Gender similarities in:
  - Disliked body areas, repetitive behaviors
  - Sx severity, suicidality, comorbidity, illness course
  - Receipt of cosmetic procedures

- Males
  - More likely **genital preoccupation**
  - **Muscle dysmorphia** almost exclusively in males

- Females
  - More likely **comorbid eating disorder**

Body Dysmorphic Disorder – Suicide Risk

- High rates of SI + SA in all ages
  - **Adolescents → higher risk of completed suicide**
  - Substantial attribution to **appearance concerns**

- Suicide risk factors
  - High rates of SI, SA
  - High rates of comorbid MDD
  - Demographic characteristics

Body Dysmorphic Disorder – Functional Consequences

- Nearly all → impaired psychosocial functioning
  - Severity of BDD sx → poorer functioning, QoL
    - On average → markedly poor
    - Moderate (avoidance of some social situations)
    - Extreme (completely housebound)
  - Occupational, academic, role functioning, social
    - **20% of youth drop out of school**
  - High proportion have been **psychiatrically hospitalized**

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Body Dysmorphic Disorder – Differential Diagnosis

- Normal appearance concerns, clearly noticeable defects
  - if skin lesions result of skin picking assoc with BDD → dx BDD
- Eating disorders → can dx BOTH
  - Concerns of being fat, weight (with assoc ED sx)
- Other OC&R disorders
  - BDD → **POORER insight,** focus on appearance/improving appearance
- Major depressive disorder → can dx BOTH
- Illness anxiety disorder
- Anxiety disorders
- Psychotic disorders

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Body Dysmorphic Disorder – Differential Diagnosis

- Other disorders + symptoms
  - **Gender dysphoria** → may have discomfort/desire to be rid of sex traits
  - **Olfactory reference syndrome** → emitting foul odor
  - **Body identity integrity syndrome** → desire to have limb amputated
  - **Koro** → fear penis is shrinking/retracting with resulting death (SE Asia)
  - **Dysmorphic concern** → broader concern, not equivalent to BDD

Body Dysmorphic Disorder – Comorbidity

- **MDD** → MOST COMMON comorbidity
  - Onset usually AFTER BDD

- <u>Other common comorbidities</u>
  - Social anxiety disorder
  - OCD
  - Substance-related disorders

Hoarding Disorder

Hoarding Disorder – Diagnostic Criteria

A. Difficulty **discarding possession** (regardless of actual value)
B. Perceived **need to save** items, **distress when discarding**
C. Results in **accumulation**, congesting + **compromising active living areas** (or requiring intervention from third parties)

D. Significant distress or impairment
E. Not due to AMC (brain injury, cerebrovascular disease, Prader-Willi syndrome)
F. Not better explained by AMD (OCD, MDD, psychosis, NCD, ASD)

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Hoarding Disorder – Diagnostic Specifiers

- *Specify if:*
  - **With excessive acquisition:** 80-90% of hoarding disorder
    - Most frequently excessive buying, then free items
    - Stealing LESS common
    - May appear later in course
    - May have distress if unable/prevented from acquiring

- *Specify if:*
  - **With good or fair insight:** recognizes problematic
  - **With poor insight:** mostly convinced not problematic
  - **With absent insight/delusional beliefs:** completely convinced not problematic

Hoarding Disorder – Diagnostic Features

- A) Difficulty discarding possible, regardless of value
  - Long-standing (not transient, like inheriting property)
  - **Any discarding** → disposing, selling, giving away, recycling
  - Due to perceived **utility**, **aesthetic** value, **strong sentimental** attachment
    - Feel **responsible** for fate of possession
    - Great lengths to **avoid being wasteful**
    - Fear of **losing important information**
  - Most common items
    - Newspapers, magazines, books, mail, paperwork
    - Old clothing, bags
  - Not necessarily useless or limited value → **can save valuable things** too

Hoarding Disorder – Diagnostic Features

- B) **Purposefully** save possession, distress assoc with discarding
  - Distinguishes from passive accumulation, no distress when items removed

- C) Active living areas cluttered, **unable to use as intended**
  - Clutter → large group of unrelated objects piled together, disorganized, in space designed for other purposes
  - Active living areas → not just attic, basements, garages
  - Items may spill beyond active living areas
  - May be uncluttered due to **third-party intervention** or **forced to clear**

- Normal collecting → organized, systematic (may still be a lot)
  - Does not produce clutter, distress or impairment

- If poor insight → may not report distress
  - But high distress if attempts to remove possessions

Hoarding Disorder – Associated Features

- Other common features
  - Indecisiveness, procrastination, avoidance, perfectionism
  - Difficulty planning/organizing, distractibility
  - Some may live in **unsanitary conditions** (as a consequence)

- Animal hoarding (may be special manifestation)
  - **Large numbers**
    - Failure to provide **minimal standards or care**
    - Failure to act on **deteriorating conditions** of animals or environment
    - Most also hoard inanimate objects
  - MOST PROMINENT differences in animal hoarding (vs object)
    - **Extent of unsanitary conditions**
    - **Poorer insight**

Hoarding Disorder – Prevalence

- Community point prevalence = **2 – 6%** (US/EU)
  - No national data
  - Some epidemiological study → higher in males
  - Clinical samples → higher in females

- **3x MORE prevalent** in **older adults (age 55-94)** (vs age 33-44)

Hoarding Disorder – Development & Course

- May appear early life, span into late life
  - Symptoms may start around **age 11-15**
  - Interfering with function by **mid-20s**
  - Clinically significant by **mid-30s**
  - Most research participants in **age 50s**

- Severity INCREASES with age
  - Once sx being → often **chronic**
  - Few report waxing/waning course

- Children
  - Pathological gambling vs **developmentally adaptive saving/collecting**
  - Consider role of third parties (because C&A typically do not control environment)

Hoarding Disorder – Risk & Prognostic Factors

- Temperamental
  - **Indecisiveness** = prominent features among pts + 1º relatives
- Environmental
  - Often report **stressful + traumatic life events**
    - Either preceding onset, or causing exacerbation
- Genetic & Physiological
  - **Familial → 50%** have relative who also hoards
  - Twin studies → **50%** of variability attributable additive **genetic factors**

Hoarding Disorder – Culture-Related Issues

- Universal phenomenon
  - **Consistent clinical features**
  - Western, non-Western, industrialized, developing, urban

Hoarding Disorder – Gender-Related Issues

- Key features general similar
  - Difficulties discarding, excessive clutter

- FEMALES → more **excessive acquisition** (esp buying)

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Hoarding Disorder – Functional Consequences

- Clutter impairs basic activities
  - Moving through house, cooking, cleaning, hygiene, sleeping
  - Broken appliances, disconnect utilities, difficult access for repair

- Impaired quality of life → health risks (esp elderly)
  - Fires, falls, poor sanitation
  - Occupational impairment, poor physical health
  - High social service utilization

- Relationships
  - **Family relationships** → frequently greatly strained
  - Conflict with **neighbors, local authorities** common
  - **Legal evictions** in substantial % of severe hoarding disorder

Hoarding Disorder – Differential Diagnosis (1)

- Other medical conditions
  - AMC → TBI, surgery for tumor/seizure control, cerebrovascular disease, CNS infection (herpes simplex encephalitis), Prader-Willi syndrome
  - Damage to **anterior ventromedial prefrontal + cingulate cortices**

- OCD → if severe, may dx both
  - Hoarding sx may be direct consequence of obsessions/compulsions
  - **"Feeling of incompleteness"** most frequently assoc with this form
  - Generally **unwanted, highly distressing, no pleasure, onerous rituals**
  - Usually **no excessive acquisition**, more likely bizarre items

- NCD
  - Follows gradual onset, assoc with self-neglect/squalor
  - Other neuropsychiatric sx → disinhibition, gambling, stereotypies, tics

Hoarding Disorder – Differential Diagnosis (2)

- Neurodevelopmental disorders
- Schizophrenia spectrum disorders
- Major depressive episode

Hoarding Disorder – Comorbidity

- Comorbid mood/anxiety disorder → **75%**
  - Most common:
    - **Major depressive disorder** (up to 50%)
    - Social anxiety disorder
    - GAD

- Also meet criteria for OCD → **20%**

- Comorbidities usually reason for consultation
  - Unlikely to spontaneously report hoarding sx

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Trichotillomania

Trichotillomania – Diagnostic Criteria

A. **Recurrent hair pulling**, resulting in **hair loss**
B. Repeated **attempts to decrease/stop** hair pulling

C. Significant distress or impairment
D. Not due to AMC (e.g. dermatological)
E. Not better explained by AMD (e.g. BDD)

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Trichotillomania – Diagnostic Features

- A) Recurrent pulling out of one's own hair
  - Any region → site may vary over time
    - MOST common → **scalp, eyebrows, eyelids**
    - Less common → **axillary, facial, pubic, peri-rectal**
  - Timing varies
    - Brief episodes throughout day
    - Less frequent episodes, but more sustained (hours)
    - May endure for months-years
  - Hair loss
    - May pull hair in **widely distributed pattern** → not clearly visible
    - May attempt to **conceal or camouflage** hair loss

- B) Repeated attempts to decrease or stop

- C) Distress (negative affects) or impairment (avoidance)

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Trichotillomania – Associated Features

- May have behaviors or rituals involving hair
  - Search for **particular kind of hair** (texture, color)
  - Pull out hair in **specific way** (root intact)
  - **Examine visually**, manipulate **tactilely/orally** after pulled

- Accompanied/preceding emotional states
  - May be triggered by **anxiety, boredom**
  - May be preceded by **increasing sense of tension**
  - May lead to **gratification, pleasure, sense of relief** after hair pulled
  - **"Itch-like"** or tingling sensation → alleviated by pulling hair
  - **Pain does NOT** usually accompany

- Varying degrees of conscious awareness
  - More focused attention → preceding tension, subsequent relief
  - More automatic behavior → without full awareness
  - **Usually a mix**

Trichotillomania – Associated Features

- Variable patterns of hair loss
  - **Complete alopecia**, or **areas of thinned hair density** → COMMON
  - If scalp involved → may prefer pulling from **crown or parietal regions**
  - May be **nearly complete baldness**
    - Except **narrow perimeter** around outer margin of scalp
    - Particularly at **nape of neck** ("tonsure trichotillomania")
  - Eyebrows + eyelashes may be completely absent
- Sometime urges to pull hair from others (surreptitiously)
  - Pets, dolls, sweaters, carpet
  - May have other body-focused behaviors (skin-pick, nail bite, lip chew)
- Usually does NOT occur in presence of others, just family
- May deny hair pulling to others

Trichotillomania – Development & Course

- Hair pulling may be seen in infants → typically resolves
- Onset → most commonly around **puberty**
- Course → usually **chronic**, some **wax/wane** if untreated
  - May come/go for weeks-months-years
  - **Minority remit**, without relapse, within few years of onset
  - May worsen in FEMALES with **hormonal changes**
    - Menstruation, perimenopause

Trichotillomania – Risk & Prognostic Factors

- Genetic & Physiological
  - Genetic vulnerability
  - More common if **comorbid OCD** or **1º relative with OCD**

Trichotillomania – Culture-Related Issues

- Similar manifestation across cultures
  - Paucity of data from non-Western regions

Trichotillomania – Diagnostic Markers

- Dermatopathological dx rarely required (most admit hair pulling)
  - Skin biopsy/dermoscopy, trichoscopy → differentiate causes of alopecia
  - Dermoscopy in trichotillomania
    - **Decreased hair density**
    - **Short vellus hair**
    - **Broken hairs with different shaft lengths**

Trichotillomania – Functional Consequences

- Distress, social/occupational impairment

- Physical consequences
  - May **irreversible damage** to hair growth + quality
  - Digit purpura
  - MSK injury (carpal tunnel syndrome, pain in back/shoulder/neck)
  - Blepharitis
  - Dental damage (hair biting)
  - **Trichobezoars** (from trichophagia)
    - Anemia, hematemesis, nausea, vomiting
    - Abdo pain, bowel obstruction, perforation

Trichotillomania – Differential Diagnosis (1)

- Normative hair removal/manipulation
  - Do NOT dx if **solely for cosmetic reasons**
  - Do NOT dx if just twisting, playing, biting hair
- Other OC&R disorders
  - Do NOT dx if **OCD** with symmetry rituals
  - Do NOT dx if **BDD** with perceiving hair as ugly, abnormal
- Neurodevelopmental disorders
  - Hair pulling may be **stereotypy** (in stereotypic movement disorder)
  - Tics RARELY lead to hair pulling
- Psychotic disorders
  - Not due to delusions/hallucinations

Trichotillomania – Differential Diagnosis (2)

- Another medical condition
  - Skin inflammation, dermatological conditions
  - **Scarring alopecia** (alopecia, areata, androgenic alopecia, telogen effluvium)
  - **Non-scarring alopecia** (chronic discoid lupus erythematosus, lichen planopilaris, central centrifugal cicatricial alopecia, pseudopelade, folliculitis decalvans, dissecting folliculitis, acne keloidalis nuchae)
  - Differentiate with **skin biopsy or dermoscopy**

- Substance-related disorders
  - Hair pulling may be exacerbated by certain substances **(stimulants)**

Trichotillomania – Comorbidity

- Often comorbid mental disorders
  - MOST common = **MDD, excoriation disorder**

- Majority have other repetitive body-focused sx

Excoriation Disorder

Excoriation Disorder – Diagnostic Criteria

A. Recurrent **skin picking**, resulting in **skin lesions**
B. Repeated **attempts to decr/stop** skin picking

C. Significant distress or impairment
D. Not due to substances or AMC
E. Not better explained b AMD

Excoriation Disorder – Diagnostic Features

- A) Recurrent picking at one's own skin
  - Many pick from multiple body sites
    - MOST COMMON sites = **face, arms, hands**
    - Healthy skin, minor irregularities, lesions (pimples, calluses)
    - Scabs from previous picking
  - May use **fingernails**, tweezers, pins, other objects
  - May be skin rubbing, squeezing, lancing, biting
  - Often spend **significant time** (hours per day)
    - May endure for months-years
  - Requires **skin lesions** → often concealed/camouflaged

- B) Repeated attempts to decr/stop

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Excoriation Disorder – Associated Features

- May have behaviors or rituals involving skin or scabs
  - Search for **particular kind of scab**
  - May **examine, play with, mouth or swallow** skin after
- Accompanied/preceding emotional states
  - May be triggered by **anxiety, boredom**
  - May be preceded by **increasing sense of tension**
  - May lead to **gratification, pleasure, sense of relief** after picking
  - May be in response to **minor skin irregularity, relieve discomfort**
  - **Pain does NOT** usually accompany
- Varying degrees of conscious awareness
  - More focused attention → preceding tension, subsequent relief
  - More automatic behavior → without full awareness
  - **Usually a mix**
- Usually does NOT occur in presence of others, just family
  - May report picking skin of others

Excoriation Disorder – Prevalence

- Lifetime prevalence = **1.4%** (adults)
  - Higher in **FEMALES (75% or more)**

DSM5

Excoriation Disorder – Development & Course

- May present at various ages
  - Onset usually during adolescence → **around puberty**
  - Frequently begins **with a dermatological condition** (e.g. acne)
  - Site of picking may vary over time

- Course → usually **chronic**, some **wax/wane** if untreated
  - May come/go for weeks-months-years at a time

Excoriation Disorder – Risk & Prognostic Factors

- Genetic & Physiological
  - More common if **comorbid OCD** or **1º relative with OCD**

Excoriation Disorder – Diagnostic Markers

- Dermatopathological diagnosis rarely required
  - **Most admit to skin picking**
  - May have characteristic features on histopathology

Excoriation Disorder – Functional Consequences

- Distress + social/occupational impairment
  - **>1 hour per day** → picking, thinking about picking, resisting urges
  - **Avoidance** → social, entertainment, going out in public
  - Majority have **work interference** (daily to weekly basis)
  - Many have **school difficulties** (attendance, studying, responsibilities)

- Medical complications
  - Tissue damage, scarring, infection → can be life-threatening
    - Frequently requires **antibiotic treatment**
    - Occasionally may require surgery
  - Rarely, **wrist synovitis** (due to chronic picking)

Excoriation Disorder – Differential Diagnosis

- Psychotic disorder
  - Skin picking due to delusion **(parasitosis)** or tactile halluc **(formication)**

- OC&R disorders
  - Do NOT dx if related to OCD with contamination obsessions
  - Do NOT dx if related to BDD picking due to appearance concerns

- Neurodevelopmental disorders
  - **Stereotypic** movements with repetitive self-injury → in early development
  - **Prader-Willi** → may have early onset skin picking
    - May meet criteria for stereotypic movement disorder
  - **Tourette's disorder** → tics (not tic-like in excoriation disorder)

Excoriation Disorder – Differential Diagnosis

- Somatic symptom & related disorders
  - Do NOT dx if due to **deceptive behaviors in factitious disorder**
- Other disorders
  - Do NOT dx if intentional non-suicidal self-injury
- Other medical conditions
  - **Scabies** → severe itching + scratching
  - **Acne** → may lead to picking
    - May be assoc with comorbid excoriation disorder
    - Whether picking independent of underlying dermatological condition
- Substance/medication-induced disorders
  - Cocaine

Excoriation Disorder – Comorbidity

- Often comorbid mental disorders
  - **OCD, trichotillomania**
  - **Major depressive disorder**

- Many have other repetitive body-focus symptoms
  - May deserve additional dx of **other specific OC&R disorder**
    - "Body-focused repetitive behavior disorder"

Substance/Medication-Induced Obsessive-Compulsive & Related Disorder

Sub/Med-Induced OC&RD – Diagnostic Criteria

A. Obsessive-compulsive sx predominate clinical picture

B. History, physical exam, lab findings of:
   1. Symptom onset **during/soon after** → intoxication, withdrawal, exposure
   2. Substance/medication **capable** of producing symptoms

C. Not non-substance/medication-induced
   1. Symptom onset preceding sub/med use
   2. Symptom persistence after cessation of sub/med use/intox/withdrawal
   3. Other evidence (previous non-sub/med-induced episodes)

D. Not exclusively during **delirium**

E. Significant distress or impairment

Sub/Med-Induced OC&RD – Diagnostic Specifiers

- *Specify substance:*
  - Amphetamine (or other stimulant)
  - Cocaine
  - Other (or unknown) substance

- *Specify onset:*
  - **With onset during intoxication**
  - **With onset during withdrawal**
  - **With onset after medication use**

Sub/Med-Induced OC&RD – Diagnostic Features

- Diagnose in addition to substance intoxication if:
  - Symptoms predominate clinical picture
  - Sufficiently severe to warrant independent clinical attention

Sub/Med-Induced OC&RD – Associated Features

- Associated with:
  - **Stimulants (including cocaine)**
  - Other (or unknown) substances
  - **Heavy metals, toxins**

Sub/Med-Induced OC&RD – Prevalence

- Very limited data → indicates **very rare**

Sub/Med-Induced OC&RD – Differential Diagnosis

- Substance intoxication
  - Usually sufficient → unless in excess, severe to warrant dx

- Other OC&R disorders
- OC&R due to AMC
- Delirium

Obsessive-Compulsive & Related Disorder due to AMC

OC&RD due to AMC – Diagnostic Criteria

A. Obsessive-compulsive sx predominate clinical picture

B. Evidence of **direct pathophysiological consequence** of AMC

C. Not better explained by another mental disorder

D. Not exclusively during delirium

E. Significant distress or impairment

DSM5

OC&RD due to AMC – Diagnostic Specifiers

- *Specify if:*
  - **With obsessive-compulsive disorder-like symptoms**
  - **With appearance preoccupations**
  - **With hoarding symptoms**
  - **With hair-pulling symptoms**
  - **With skin-picking symptoms**

OC&RD due to AMC – Diagnostic Features

- Relevant medication condition present
  - Clear temporal associate
  - Atypical features (late age at onset, course)
  - Known physiological mechanism **(striatal damage)**

OC&RD due to AMC – Diagnostic Features

- Group A streptococcal infection
  - **Sydenham's chorea** → neurological manifestation of rheumatic fever
    - Non-motor: **obsessions, compulsions, inattention, labile mood**
    - May present without non-neuropsychiatric sx (carditis, arthritis)

  - **PANDAS** (pediatric autoimmune neuropsychiatric disorders assoc with streptococcal infections) → post-infectious autoimmune disorder
    - Sudden onset of **obsessions, compulsions, tics**
      - With other acute neuropsychiatric sx
      - Without chorea, carditis, arthritis
    - Controversial dx still
      - PANS (pediatric acute-onset neuropsychiatric syndrome)
      - CANS (idiopathic childhood acute neuropsychiatric symptoms)

OC&RD due to AMC – Associated Features

- Several associated medical disorders
  - Disorders leading to **striatal damage** (cerebral infarction)

OC&RD due to AMC – Development & Course

- Follows course of underlying AMC

OC&RD due to AMC – Diagnostic Markers

- Labs + medication exam necessary

OC&RD due to AMC – Differential Diagnosis

- Delirium
- Major NCD → can dx both if same pathological process
- Associated feature of another mental disorder
  - Schizophrenia, anorexia nervosa, etc.
- Illness anxiety disorder

- Primary OC&RD
- Mixed presentation of symptoms (mood, OC&RD sx)
  - Which symptoms predominate clinical picture
- Sub/med-induced OC&RD
- Other specified/unspecified OC&RD (if unclear)

Other Specified OC&RD

Other Specified OC&RD

- Does not meet any full criteria
- Clinician choose to specific reason

- Body dysmorphic-like disorders with actual flaws
- Body dysmorphic-like disorders without repetitive behaviors
- Body-focused repetitive behavior disorder
- Obsessional jealousy → non-delusional preoccupation

- *Shubo-kyofu* → related to *taijin kyofusho,* fear of having bodily deformity
- *Jikoshu-kyofu* → related to *taijin kyofusho,* fear of having offensive body odor (also *olfactory reference syndrome*)
- *Koro* → related to *dhat syndrome,* fear penis will recede, leading to death

Unspecified OC&RD

Unspecified OC&RD

- Does not meet any full criteria
- Clinician choose NOT to specific reasons