Obsessive-Compulsive and related disorders

Dr Sadia Malik

Obsessive-Compulsive and related disorders include obsessive-compulsive disorder (OCD), body dysmorphic disorder, hoarding disorder, trichotillomania (hairpulling disorder), excoriation (skin-picking) disorder, substance/medication-induced obsessive-compulsive and related disorder, obsessive-compulsive and related disorder due to another medical condition, and other specified obsessive-compulsive and related disorder and unspecified obsessive-compulsive and related disorder (e.g., body-focused repetitive behavior disorder, obsessional jealousy).

OCD is characterized by the presence of obsessions and/or compulsions. *Obsessions* are recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, whereas *compulsions* are repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly. Some other obsessive-compulsive and related disorders are also characterized by preoccupations and by repetitive behaviors or mental acts in response to the preoccupations. Other obsessive-compulsive and related disorders are characterized primarily by recurrent body-focused repetitive behaviors (e.g., hair pulling, skin picking) and repeated attempts to decrease or stop the behaviors.

Obsessive-Compulsive Disorder

Diagnostic Criteria 300.3 (F42)

A. Presence of obsessions, compulsions, or both:
Obsessions are defined by (1) and (2):
1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).
Compulsions are defined by (1) and (2):
1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.
Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder

(*Specify* if:

With good or fair insiglit: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true.

With absent insight/deiusionai beiiefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

***Specify* if:**

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Table 1. Typical OCD Symptoms

Common Obsessions	Common Compulsions
Contamination fears of germs, dirt, etc.	Washing
Imagining having harmed self or others	Repeating
Imagining losing control of aggressive urges	Checking
Intrusive sexual thoughts or urges	Touching
Excessive religious or moral doubt	Counting
Forbidden thoughts	Ordering/arranging
A need to have things "just so"	Hoarding or saving
A need to tell, ask, confess	Praying

Common OCD obsessions include

Contamination	Losing control	Perfectionism	Harm	Religious obsessions
• Body fluids • Germs and disease • Environmental contaminants • Household chemicals • Dirt	• Fear of acting on urge to harm oneself • Fear of acting on urge to harm others • Fear of violent or horrific images featuring in one's mind • Fear of yelling out insults or swearing • Fear of stealing things.	• concern about evenness or exactness • Concern with a need to know or remember • Fear of losing or forgetting important information • Unable to decide whether to keep or discard things.	• Fear of being responsible for something terrible happening • Fear of harming others because of not being careful enough.	• Concern with offending God or blasphemy • Superstitious ideas about lucky/unlucky numbers and certain colors.

Unwanted sexual thoughts	Other obsessions
• Forbidden or perverse sexual thoughts or images • Forbidden or perverse sexual thoughts or urges about others • Obsession about homosexuality • Sexual obsessions that involve children or incest • Obsessions about aggressive sexual behavior toward others.	• Concern with getting a physical illness or disease • Superstitious ideas about lucky/unlucky numbers and certain colors.

Compulsions

- Not all "rituals" or forms of repetitive behavior are compulsions. Normal and welcome repetitive behavior that feature in everyday life may include bedtime routines, religious practices, learning a new skill. Behavior also depends on the context, for example, a person who works in a video store arranging DVDs for eight hours a day does not have a compulsion.

Common OCD compulsions include:

Washing and cleaning	Checking	Repeating
• Constant hand-washing in a certain way • Excessive showering, bathing, tooth brushing, grooming or toilet routines • Cleaning household items or other objects too much • Doing other things to prevent or remove contact with contaminants.	• Checking that you did not/will not harm others • Checking that you did not/will not harm yourself • Checking that nothing terrible happened • Checking that you did not make a mistake • Checking some parts of your physical condition or body.	• Rereading or rewriting • Repeating routine activities (examples: going in or outdoors, getting up and down from chairs) • Repeating body moments (example: tapping, touching, blinking) • Repeating activities in "multiples" (example: doing a task three times because three is a "good," "right," "safe" number).

Mental compulsions	Other compulsions
• Mental review of events to prevent harm • Praying to prevent harm (to oneself, others, to prevent terrible consequences) • Counting while performing a task to end on a "good," "right," or "safe" number • "Canceling out" or "undoing" (example: replacing a "bad" word with "good" word to cancel it out).	• Collecting items which results in significant clutter in the home (hoarding) • Putting things in order or arranging things until it "feels right" or symmetrical • Telling, asking, confessing to get reassurance • Avoiding situations that might trigger your obsessions.

What causes OCD?

- Genetics
- Studies have shown that OCD runs in families and can be considered a "familial disorder."[7] The disease may span generations with close relatives of people with OCD significantly more likely to develop OCD themselves.
- Twin studies of adults suggest that obsessive-compulsive symptoms are moderately heritable, with genetic factors contributing 27-47% of variance in scores on measures of obsessive-compulsive symptoms.[8-10] In studies of obsessive-compulsive symptoms in children, genetic factors account for 45-65% of variance.[10]

- Autoimmunity
- Some rapid onset cases of obsessive-compulsive disorder in children might be a consequence of Group A streptococcal infections, which cause **inflammation** to and dysfunction of the basal ganglia.
- Neurological
- Brain imaging techniques have allowed researchers to study the activity of specific areas of the brain. Despite recognition that some parts of the brain are different in OCD sufferers compared with non-sufferers, it is not known exactly how these differences relate to the development of OCD.
- The areas of the brain that have unusual activity in sufferers and are suggested to be involved with symptoms of OCD include the:
- Orbitofrontal cortex
- Anterior cingulate cortex
- Striatum
- Thalamus
- Anterior cingulate gyrus
- Caudate nucleus
- Basal ganglia.

- The circuit between the above areas regulates primitive aspects of behavior such as aggression, sexuality and bodily excretions. When activated, the circuit causes an urge to come to a person's attention and cause a particular appropriate behaviour. Experts suggest that in people with OCD, the brain has difficulty turning off and **ignoring urges** from the circuit, which creates **communication problems** in these brain areas; the obsessions and compulsions continue, leading to **repetition of the behavior**, such as continual hand-washing.
- There is a possible link between low levels or imbalance of one neurotransmitter, called serotonin and the development of OCD. This link seems to involve the pathways of the brain that connect the area of the brain that deals with judgment and planning and the area of the brain that filters messages involving body movements. Serotonin is responsible for regulating a number of the body's functions, including mood, **anxiety**, memory and sleep.

Behavioral theory

- The behavioral theory suggests people with OCD **associate** certain objects or situations with **fear** and learn to avoid those things that **trigger fear** or to **perform "rituals"** in order to help **reduce the fear**.
- This fear and avoidance/ritual cycle may begin when an individual is under high periods of **stress**, such as starting a new job or the ending of a relationship.
- Once the connection between and object and the feeling of fear becomes established, people with OCD begin to avoid that object and the fear it generates, rather than confronting or tolerating the fear.
- For example, a person who has always been able to use a public restroom may, when under stress, make a connection between the toilet seat and a fear of catching an illness. This person then avoids using public restrooms or when forced to, will perform elaborate cleaning rituals, such as cleaning the seat, door handles or following a detailed washing procedure. These actions will temporarily relieve the level of fear and because the fear is never challenged or dealt with the behavior is reinforced. The associated of fear may spread to other similar objects such as public sinks, showers, etc.

Cognitive theory

- The behavioral theory above focuses on how people with OCD make an **association** between an object and fear, whereas, the cognitive theory focuses on how people with OCD **misinterpret** their thoughts.
- Most people have unwelcome or intrusive thoughts but for those with OCD the importance of those thoughts are exaggerated.
- For example, a person who is under pressure and stress nurturing an infant may have an intrusive thought of harming the infant. Most people can shrug off and disregard the thought. People suffering from OCD exaggerate the importance of the thought and respond as though it signifies a threat. In the mind of the sufferer a fleeting thought is changed to a dangerous intention, believing that they may be a threat to the child, which causes anxiety and negative emotion such as disgust, guilt and shame.
- OCD sufferers who fear their own thoughts attempt to neutralize negative feelings that arise from their thoughts by avoiding the situations that trigger the thoughts or engaging in rituals such as excessively self-cleaning or praying.
- As long as these intrusive thoughts are interpreted as cataclysmic by the sufferer and believe that they are true, the person will continue the avoidance and ritual behaviors.

- Researchers suggest sufferers who attach exaggerated danger to their thoughts do so because of false beliefs learned earlier in life. Some of these beliefs that could possibly assist in the development and preservation of obsessions include:
- **Exaggerated responsibility** - believing that one is solely responsible for the safety of or the harm of others
- **Exaggerated thought importance** - believing certain thoughts have more importance and need to be controlled
- **Exaggerated future impact** - believing a thought or urge to do something will increase the likelihood that it will happen
- **Exaggerated danger limitation** - the tendency to overestimate the likelihood of danger
- **Exaggerated perfectionism** - believing everything should be perfect and mistakes are unacceptable.

Environmental theory

- Environmental stressors may be a trigger for OCD in people with a tendency toward developing the condition. Twin studies of adults suggest that obsessive-compulsive symptoms that are attributed to environmental factors contribute 53-73% of variance in scores on measures of obsessive-compulsive symptoms.[8-10] Overall, studies indicate that patients with OCD frequently report stressful and traumatic life events before the illness begins.[6] These events may also cause a worsening of the symptoms. Possible environmental factors include:
- Abuse
- Changes in living situation
- Illness
- Death of a family member or friend
- School or work changes and problems
- Relationship worries.

CBT

- CBT has been found to be an effective method to treat OCD. CBT is one type of psychotherapy (talking therapy) that aims to help the patient change the way they think, feel and behave and refers to two distinct treatments:
- Exposure and response prevention (ERP)
- Cognitive therapy.
- Research has shown that 75% of people with OCD are significantly helped by cognitive behavioral therapy.

Exposure-Response Prevention

- ERP is considered an important aspect of CBT for OCD.
- **Exposure:** Part of this treatment involves **imagined or direct exposure** to **situations and objects** that **trigger obsessions** that cause **fear and anxiety** in the individual. Over time anxiety generated by these obsessional cues decrease and eventually causes little or no anxiety at all. This process of becoming "used to" obsessional cues is called habituation.
- **Response:** Response prevention refers to the ritual behaviors that people with OCD engage in to reduce anxiety. Patients learn to **resist** the **compulsion** to perform these **rituals** in the treatment with the view that eventually they are able to stop engaging in the behaviors.
- Patients initially make a "hierarchy" list of situations that provoke obsessional fears. Treatment begins with exposure to each of these situations whether imaginary or in reality, moving gradually from those that cause low-mild anxiety to those that cause greater anxiety.
- The target of this exposure to the obsessional fears is for the person to be put in front of the obsessional trigger without engaging in ritualistic behavior.

How does ERP work?

- Before starting ERP treatment, patients make a list, or what is termed a "hierarchy" of situations that provoke obsessional fears. For example, a person with fears of contamination might create a list of obsessional cues that looks like this:
- 1. touching garbage
- 2. using the toilet
- 3. shaking hands.
- Treatment starts with exposure to situations that cause mild to moderate anxiety, and as the patient habituates to these situations, he or she gradually works up to situations that cause greater anxiety. The time it takes to progress in treatment depends on the patient's ability to tolerate anxiety and to resist compulsive behaviours.
- Exposure tasks are usually first performed with the therapist assisting. These sessions generally take between 45 minutes and three hours. Patients are also asked to practice exposure tasks between sessions for two to three hours per day.

- The main goal during both in vivo and imaginal exposure is for the person to stay in contact with the obsessional trigger without engaging in ritual behaviours. For example, if the person who fears contamination responds to the anxiety by engaging in handwashing or cleaning rituals, he or she would be required to increasingly resist such activities - first for hours, and then days following an exposure task.
- The therapy continues in this manner until the patient is able to abstain from ritual activities altogether.
- To mark progress during exposure tasks with the therapist and in homework, patients are trained to be experts in rating their own anxiety levels.
- Once they have made progress in treatment, participants are encouraged to continue using the ERP techniques they have learned, and to apply them to new situations as they arise.
- A typical course of ERP treatment is between 14 and 16 weeks.

Cognitive therapy (CT)

- When patients participate in "exposure" tasks in exposure and response prevention therapy, they are asked to take note of thoughts and feelings (obsessions) that are activated in the situation. CT focuses on:
- How patients interpret their obsession
- What the person believes or assumes to be true
- What their attitude is to the situation
- Why they think, they have an obsession.
- Participants of CT work toward **eliminating** compulsive behavior by **identifying and re-evaluating** beliefs of the consequences of engaging or not engaging in the compulsive behavior.

- Thought records might be used to identify, challenge and correct negative interpretations with questions such as:
- **Situation:** Where was I when the obsession started?
- **Intrusive thought:** What intrusive thought, image or idea did I have?
- **Meaning:** What meaning did I assign to that intrusive thought, image or idea?
- **Ritual/Compulsion:** What did I do?
- Once these intrusive thoughts and the meanings the person applies to them are acknowledged, the next steps that may be taken with the therapist is to:
- Examine the evidence that supports and does not support the obsession
- Identify cognitive distortions in the appraisals of the obsession
- Develop a less threatening and alternative response to the intrusive thought, image or idea.

- In many cases, CBT alone is highly effective in treating OCD, but for some people a combination of CBT and medication is also effective. Medication such as SSRIs discussed below may reduce the anxiety enough for a person to start, and eventually succeed, in therapy.

Body Dysmorphic Disorder

Diagnostic Criteria 300.7 (F45.22)

A. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.

B. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.

C. The preoccupation causes clinically significant distress or impairment in social, occupational,
or other important areas of functioning.

D. The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.

***Specify* if:**

With muscle dysmorphia: The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. This specifier is used even if the individual is preoccupied with other body areas, which is often the case.

***Specify* if:**

Indicate degree of insight regarding body dysmorphic disorder beliefs (e.g., "I look ugly" or "I lool< deformed").

With good or fair insight: The individual recognizes that the body dysmorphic disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight: The individual thinks that the body dysmorphic disorder beliefs are probably true.

With absent insight/delusionai beliefs: The individual is completely convinced that the body dysmorphic disorder beliefs are true.

- Many people can have a poor body image, seeing their general physical appearance in a negative light (e.g., “I hate my body”). However, the term Body Dysmorphic Disorder, or BDD, is used to describe a particular more specific type of body image problem. BDD is marked by an intense preoccupation with a perceived flaw in one’s physical appearance. Individuals with BDD often spend significant periods of time worrying about and evaluating a particular aspect of their appearance. Large amounts of time may be spent checking their appearance in the mirror, comparing their appearance with others, and engaging in behaviours designed to try to hide or conceal the area of concern.

While the preoccupation may be with any body part, and can change over time, the most common areas that people with BDD report as being problematic include:

- Skin including acne, wrinkles or complexion
- Thinning or excessive hair on the head or body
- Nose size or shape
- Eyes or eyebrows
- Lips, smile, teeth or mouth
- Cheeks, chin or jaw
- Ears
- Overall face shape
- Legs, thighs or calves
- Genitals
- Breasts
- Buttocks
- Stomach
- Arms
- Neck
- Scars
- Height
- Muscles / build

Individuals with BDD are often concerned that the body part is too big or too small, not the right shape, asymmetrical, or out of proportion to the rest of their body.

- **Below are common examples of BDD triggers:**
- Direct negative comments (e.g., “you’re ugly”, or “bad haircut”)
- Indirect comments (e.g., “you look different today”, or a dentist asking “would you like your teeth

whitened?”)
- Perceived or actual rejection by others (e.g., a relationship break up)
- Situations where your appearance may be evaluated by others (e.g., going on a date, applying for a modelling job, meeting people for the first time)
- Situations where other’s attention may be on you (e.g., having to give a speech, be in a photograph)
- Exposure to attractive people (e.g., in magazines, on television, or in person)
- Seeing an unflattering photograph or image of yourself in a reflective surface
- Noticing a slight change in your appearance (e.g., greying hair, loss of muscular tone with age)

- There are many ways of describing this mental experience, including worrying, ruminating, brooding, evaluating, and obsessing. Whatever the term you use, this preoccupation can include numerous:
- unanswerable questions e.g., “Why do I look like this?”
- self-criticisms e.g., “I’m so ugly”
- fantasies e.g., “If I was taller, then...”
- negative comparisons e.g., “They are so much prettier than me”
- overgeneralisations e.g., “This pimple ruins my entire appearance”
- worries e.g., “What if they laugh at me?”, and
- negative reflections on the past e.g., “If I hadn’t had that treatment, then...”

- People with BDD also frequently report a range of distressing mental images regarding their appearance, which replay over and over in their minds.

- People with BDD have reported engaging in *frequent and repeated*:
- Mirror gazing, including using mirrors that magnify
- Checking their appearance in reflective surfaces e.g., shop windows
- Checking areas of their body visually, by touch, or by mentally scanning that area
- Verifying their appearance by taking a photograph or video footage of themselves
- Measuring parts of their body e.g., using tape measure or callipers
- Making comparisons e.g., by looking at old photographs of themselves, or

comparing their own appearance with that of others, and

- Asking family members, friends, and professionals about their appearance, either to reassure themself that their appearance is OK, or to reassure themself that there is a real problem by convincing others of the defect.

- Common examples of BDD safety behaviours include:
- Using make-up, hairstyles or carefully arranged clothing to conceal the area of concern or draw attention away from it
- Excessive pursuit of beauty, dental or dermatological treatments, or cosmetic surgery to correct the perceived flaw
- Engaging in behaviours such as skin-picking, hair plucking, or excessive exercise in an effort to improve the look of a particular area or your overall shape
- Only attending social events / going on dates at night or in poorly lit areas to reduce the chances of being negatively evaluated
- Holding your body in certain postures, turning your face a particular way, or covering features with your hand during conversations to hide the problem area
- Only socialising with particular trusted people to reduce the chances of being negatively evaluated
- Avoiding eye contact with others to decrease the likelihood of them looking at and evaluating you

Table 1. Overview of reasoning errors in BDD

Reasoning error	Definition	Example
Category errors	Confusing two logical distinct properties or objects.	*My sister had a nose job and got a lot of compliments. This procedure is therefore also justified for me.*
Apparently comparable events	Confusing two distinct events separated by time or place.	*Teenagers with acne get mocked, which means that I can also be laughed at if my skin is imperfect.*
Selective use of out-of-context facts	Inappropriately applying abstract facts to specific personal contexts.	*Actors with physical flaws don't get as many contracts.*
Purely imaginary sequences	Making up convincing stories and living them.	*When people look at me I feel my nose grow even bigger and I become even uglier.*
Distrust of normal perception	Disregarding the senses in favour of going deeper into reality.	*People say I look ok but it doesn't mean that I actually do.*
Inverse inference	Inferences about reality precede it rather than follows from observation.	*People in the room have laughed, which might mean I look ugly.*

Cognitive behaviour therapy

- **CBT Techniques**
- CBT is a “present-focused, short-term, goal-directed therapy,” Greenberg said. The goal of this treatment is to reduce an individual’s negative thoughts about their appearance and their compulsive behaviors—the rituals they use to quell their anxiety. These rituals can include checking themselves in the mirror, seeking reassurance from others, camouflaging the area of concern with cosmetics, clothing or tanning and picking their skin.

- Because of these many similarities, the same **Cognitive-Behavioral Therapy (CBT)** techniques that are so effective in treating OCD are also employed in BDD treatment. In fact, four recent studies have found significant reductions in symptoms using Cognitive-Behavioral Therapy for the treatment of BDD. The primary technique used in both OCD and BDD treatment is a type of Cognitive-Behavioral Therapy called "Exposure and Response Prevention" (ERP). Another CBT technique that is extremely valuable is called "Cognitive Restructuring", in which clients learn to challenge the validity of their distorted body-related thoughts.

- Additionally, a variant of ERP has been developed that has also been found to be extremely effective for the treatment of Body Dysmorphic Disorder (BDD). This method, sometimes called "imaginal exposure," involves using short stories based on the client's BDD obsessions. These stories are audiotaped and then used as ERP tools, allowing the client to experience exposure to feared situations that cannot be experienced through traditional ERP (e.g., having a large scar, being bald). When combined with standard ERP for the above-noted compulsions, and other CBT techniques such as Cognitive Restructuring, this type of imaginal exposure can greatly reduce the frequency and magnitude of intrusive BDD obsessions, as well as the individual's sensitivity to the thoughts and mental images experienced in Body Dysmorphic Disorder.

- One of the most effective CBT developments for the treatment of Body Dysmorphic Disorder (BDD) is Mindfulness-Based Cognitive-Behavioral Therapy. The primary goal of **Mindfulness-Based CBT** is to learn to non-judgmentally accept uncomfortable psychological experiences. From a mindfulness perspective, much of our psychological distress is the result of trying to control and eliminate the discomfort of unwanted thoughts, feelings, sensations, and urges. In other words, our discomfort is not the problem - our attempt to control and eliminate our discomfort is the problem. For an individual with Body Dysmorphic Disorder, the ultimate goal of **mindfulness** is to develop the ability to more willingly experience their uncomfortable thoughts, feelings, sensations, and urges, without responding with compulsions, avoidance behaviors, reassurance seeking, and/or mental rituals.

Hoarding Disorder

Diagnostic Criteria 300.3 (F42)

A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.
B. This difficulty is due to a perceived need to save the items and to distress associated with discarding them.
C. **The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).**
D. The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).
E. The hoarding is not attributable to another medical condition (e.g., brain injury, cerebrovascular disease, Prader-Willi syndrome).
F. The hoarding is not better explained by the symptoms of another mental disorder (e.g., obsessions in obsessive-compulsive disorder, decreased energy in major depressive disorder, delusions in schizophrenia or another psychotic disorder, cognitive deficits in major neurocognitive disorder, restricted interests in autism spectrum disorder).

Specify **if:**

With excessive acquisition: If difficulty discarding possessions is accompanied by excessive acquisition of items that are not needed or for which there is no available space.

Specify **if:**

With good or fair insight: The individual recognizes that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are problematic.

With poor insight: The individual is mostly convinced that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.

With absent insight/deiusionai beliefs: The individual is completely convinced that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.

Profile of a Hoarder

- More likely to live alone
- Tend to be single
- Low marriage rate, high divorce rate
- Average age for beginning to save ~ 13
- Average age for seeking treatment = 50
- Family history of hoarding is common
- Difficulties in work and social activities
- Strained family/friend relationships

Reasons for Saving

- **Sentimental** –

- “This represents my life. It’s part of me.”
- **Instrumental** –

- “I might need this. Somebody could use this.”
- **Intrinsic** –

- “This is beautiful. Think of the possibilities

Compulsive Acquisition

Compulsive Buying

- Retail/discount
- E-bay
- Home shopping network

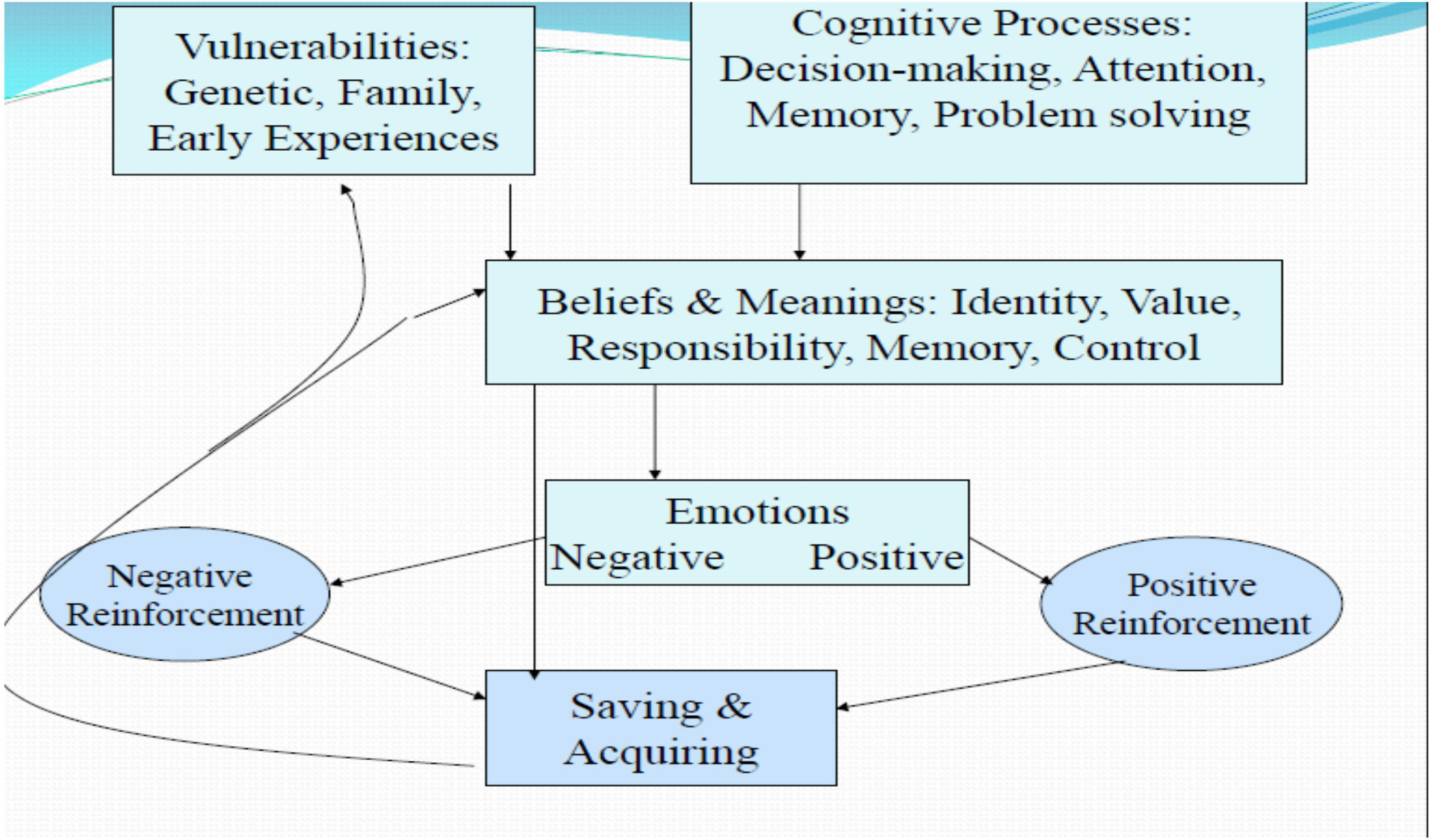
Acquisition of Free Things

- Advertising flyers/handouts
- Give-aways
- Trash - dumpster diving

Stealing/Kleptomania

Why do people Hoard?

- Vulnerabilities
- Evolutionary, biological, genetic, early experiences (attachment), core beliefs
- Information processing deficits
- Meaning/value assigned to possessions
- Positive and negative emotional reactions
- Reinforcement of acquiring and saving behaviors
- (Steketee & Frost, 2007)


Vulnerabilities: Genetic, Family, Early Experiences
Cognitive Processes: Decision-making, Attention, Memory, Problem solving
Beliefs & Meanings: Identity, Value, Responsibility, Memory, Control
Emotions
Negative
Positive
Negative Reinforcement
Positive Reinforcement
Saving & Acquiring

Specialized CBT for Hoarding

- Education and case formulation
- Determine values, set goals
- Motivational enhancement
- Skills training for organizing, problem solving, decision-making
- Practice discarding & non-acquiring
- Evaluate thoughts and beliefs
- Maintain new behaviors

Treatment Format for Adults

- 26 sessions takes about 1 yr, sometimes more in severe cases
- Individual or group
- Office and in-home sessions
- Practice in acquiring locations
- Family consultation
- Assistance from a coach if available
- Cleanouts with trained staff/coach if necessary for extensive clutt

Trichotillomania (Hair-Pulling Disorder)

Diagnostic Criteria 312.39 (F63.2)

A. Recurrent pulling out of one's hair, resulting in hair loss.
B. Repeated attempts to decrease or stop hair pulling.
C. The hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The hair pulling or hair loss is not attributable to another medical condition (e.g., a dermatological condition).
E. The hair pulling is not better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder).

Functional Consequences of Trichotillomania (Hair-Puliing Disorder)

Trichotillomania is associated with distress as well as with social and occupational impairment. There may be irreversible damage to hair growth and hair quality. Infrequent medical consequences of trichotillomania include digit purpura, musculoskeletal injury (e.g., carpal tunnel syndrome; back, shoulder and neck pain), blepharitis, and dental damage (e.g., worn or broken teeth due to hair biting). Swallowing of hair (trichophagia) may lead to trichobezoars, with subsequent anemia, abdominal pain, hematemesis, nausea and vomiting, bowel obstruction, and even perforation.

Excoriation (Skin-Picking) Disorder

Diagnostic Criteria 698.4 (L98.1)

A. Recurrent skin picking resulting in skin lesions.
B. Repeated attempts to decrease or stop skin picking.
C. The skin picking causes clinically significant distress or impairment in social, occupational,
or other important areas of functioning.
D. The skin picking is not attributable to the physiological effects of a substance (e.g., cocaine)
or another medical condition (e.g., scabies).
E. The skin picking is not better explained by symptoms of another mental disorder (e.g., delusions or tactile hallucinations in a psychotic disorder, attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder, stereotypies in stereotypic movement disorder, or intention to harm oneself in nonsuicidal self-injury).

Functional Consequences of Excoriation (Skin-Picking) Disorder

Excoriation disorder is associated with distress as well as with social and occupational impairment. The majority of individuals with this condition spend at least 1 hour per day picking, thinking about picking, and resisting urges to pick. Many individuals report avoiding social or entertainment events as well as going out in public. A majority of individuals with the disorder also report experiencing work interference from skin picking on at least a daily or weekly basis. A significant proportion of students with excoriation disorder report having missed school, having experienced difficulties managing responsibilities at school, or having had difficulties studying because of skin picking. Medical complications of skin picking include tissue damage, scarring, and infection and can be life-threatening. Rarely, synovitis of the wrists due to chronic picking has been reported. Skin picking often results in significant tissue damage and scarring. It frequently requires antibiotic treatment for infection, and on occasion it may require surgery.

- This condition is also known as dermatillomania, pathological skin picking and neurotic excoriation.
- People suffering from compulsive skin picking may pick at normal skin variations such as freckles and moles, at pre-existing skin defects such as scabs, sores oracne blemishes, or in some cases imagined skin defects that are not actually visible by others. Individuals with compulsive skin picking not only use their fingernails to pick and scratch but may also use their teeth and/or other instruments such as tweezers, blades and pins. The compulsion to scratch, pick or peel pimples is called acne excorié and could be considered a subtype of compulsive skin picking. Although any part of the body may be attacked, often the face is the targeted area.

When do BFRBs begin?

The majority of individuals start engaging in hair pulling or other BFRBs between the ages of 11 and 13. Over time, the problem may wax and wane in severity. Some children begin pulling earlier than age 13. For this group, the numbers of males and females who pull hair is about equal. However, among adult hair pullers, females outnumber males. The current research indicates that many more females than males begin pulling around the time of puberty, although the reason for this is not known. It is possible, however, that adult males are not as willing to seek treatment for their symptoms as females, and that the male-to-female ratio may actually be somewhat higher than it seems. There are some individuals who

start engaging in BFRB behavior well before adolescence. Some parents have reported observing their child engaging in hair pulling behaviors as early as 9 months old. When children of pre-school age or younger engage in hair pulling, the behavior is sometimes known as "baby trich." This behavior is often, but not always, accompanied by thumb sucking. It is thought by some experts to be less likely to develop into a long-term behavior than hair pulling that begins at a later age.

What causes BFRBs?

Why do some people engage in these behaviors while others do not? Research indicates that some people may have an inherited predisposition to skin picking or hair pulling. Several studies have shown a higher number of BFRBs in immediate family members of persons with skin picking or hair pulling than would be expected in the general population. A recent study examined hair pulling in

What is CBT?

CBT is a therapeutic approach that focuses on a person's thoughts, feelings and behaviors. Individuals learn how to change their thoughts, feelings and behaviors by employing techniques that have been shown to be effective for helping individuals reach their goals. There are a number of different treatment approaches for BFRBs that fall under the umbrella of CBT: habit reversal training, comprehensive behavioral treatment, acceptance and commitment therapy, and dialectic behavior therapy.

Habit Reversal Training

Habit Reversal Training (HRT) is an early treatment for TTM and similar problems, developed in the 1970s by Nathan Azrin and Gregory Nunn. HRT is the method that has been examined the most in research studies to date. HRT has a varying number of components in its treatment package. The three components that are considered most critical are awareness training, competing response training, and social support.

- ***Awareness training*** consists of helping the person focus on the circumstances during which pulling or picking is most likely to occur. This enables individuals to become more aware of the likelihood that the behavior will occur, and therefore provides opportunities for employing therapeutic techniques designed to discourage performance of problem behaviors.

- ***Competing response training*** teaches the individual to substitute another response for the pulling or picking behavior that is incompatible with the undesired behavior. For example, when an individual experiences an urge to pull or pick, he/she would ball up their hands into fists and tighten their arm muscles and "lock" their arms so as to make pulling or picking impossible at that moment. This response is to be repeated each time that individual experi-