

06 - Obsessive Compulsive and Related Disorders

Obsessive-Compulsive and Related Disorders

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Obsessive-Compulsive and Related Disorders Obsessive-compulsive and related disorders include obsessive-compulsive disorder (OCD), body dysmorphic disorder, hoarding disorder, trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder, substance/medication-induced obsessive-compulsive and related disorder, obsessive-compulsive and related disorder due to another medical condition, other specified obsessive-compulsive and related disorder (e.g., nail biting, lip biting, cheek chewing, obsessional jealousy, olfactory reference disorder [olfactory reference syndrome]), and unspecified obsessive-compulsive and related disorder. 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. The inclusion of a chapter on obsessive-compulsive and related disorders in DSM-5 reflects the increasing evidence of these disorders' relatedness to one another in terms of a range of diagnostic validators as well as the clinical utility of grouping these disorders in the same chapter. Clinicians are encouraged to screen for these conditions in individuals who present with one of them and be aware of overlaps among these conditions. At the same time, there are important differences in diagnostic validators and treatment approaches across these disorders. Moreover, there are close relationships between the anxiety disorders and some of the obsessive-compulsive and related disorders (e.g., OCD), which is reflected in the sequence of DSM-5 chapters, with obsessive-compulsive and related disorders following anxiety disorders. The obsessive-compulsive and related disorders differ from developmentally normative preoccupations and rituals by being excessive or persisting beyond developmentally appropriate periods. The distinction between the presence of subclinical

symptoms and a clinical disorder requires assessment of a number of factors, including the individual's level of distress and impairment in functioning. The chapter begins with OCD. It then covers body dysmorphic disorder and hoarding disorder, which are characterized by cognitive symptoms such as perceived defects or flaws in physical appearance or the perceived need to save possessions, respectively. The chapter then covers trichotillomania and excoriation disorder, which are characterized by recurrent body-focused repetitive behaviors. Finally, it covers substance/medication-induced obsessive-compulsive and related disorder, obsessive-compulsive and related disorder due to another medical condition, other specified obsessive-compulsive and related disorder, and unspecified

obsessive-compulsive and related disorder. While the specific content of obsessions and compulsions varies among individuals, certain symptom dimensions are common in OCD, including those of cleaning (contamination obsessions and cleaning compulsions); symmetry (symmetry obsessions and repeating, ordering, and counting compulsions); forbidden or taboo thoughts (e.g., aggressive, sexual, and religious obsessions and related compulsions); and harm (e.g., fears of harm to self or others and related checking compulsions). The tic-related specifier of OCD is used when an individual has a current or past history of a tic disorder. Body dysmorphic disorder is characterized by preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear only slight to others, and by repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, or reassurance seeking) or mental acts (e.g., comparing one's appearance with that of other people) in response to the appearance concerns. The appearance preoccupations are not better explained by concerns with body fat or weight in an individual with an eating disorder. Muscle dysmorphia is a form of body dysmorphic disorder that is characterized by the belief that one's body build is too small or is insufficiently muscular. Hoarding disorder is characterized by persistent difficulty discarding or parting with possessions, regardless of their actual value, as a result of a strong perceived need to save the items and distress associated with discarding them. Hoarding disorder differs from normal collecting. For example, symptoms of hoarding disorder result in the accumulation of a large number of possessions that congest and clutter active living areas to the extent that their intended use is substantially compromised. The excessive acquisition form of hoarding disorder, which characterizes most but not all individuals with hoarding disorder, consists of excessive collecting, buying, or stealing of items that are not needed or for which there is no available space. Trichotillomania is characterized by recurrent pulling out of one's hair resulting in hair loss, and repeated attempts to decrease or stop hair pulling. Excoriation disorder is characterized by recurrent picking of one's skin resulting in skin lesions and repeated attempts to decrease or stop skin picking. The body-focused repetitive behaviors that characterize these two disorders are not triggered by obsessions or preoccupations; however, they may be preceded or accompanied by various emotional states, such as feelings of anxiety or boredom. They may also be preceded by an increasing sense of tension or may lead to gratification, pleasure, or a sense of relief when the hair is pulled out or the skin is picked. Individuals with these disorders may have varying degrees of conscious awareness of the behavior while engaging in it, with some individuals displaying more focused attention on the behavior (with preceding tension and subsequent relief) and other individuals displaying more automatic behavior (with the behaviors seeming to occur without full awareness). Substance/medication-induced obsessive-compulsive and related disorder consists of symptoms characteristic of the obsessive-compulsive and related disorders developed in the context of substance intoxication or withdrawal or after exposure to or withdrawal from a medication. Obsessive-compulsive and related disorder

due to another medical condition involves symptoms characteristic of obsessive-compulsive and related disorders that are the

F42.2 direct pathophysiological consequence of another medical condition. Other specified obsessive-compulsive and related disorder (e.g., nail biting, lip biting, cheek chewing, obsessional jealousy, olfactory reference disorder [olfactory reference syndrome]) and unspecified obsessive-compulsive and related disorder consist of symptoms that cause clinically significant distress or impairment that do not meet criteria for a specific obsessive-compulsive and related disorder in DSM-5 because of atypical presentation or uncertain etiology. These categories are also used for other specific syndromes that are not listed in Section II and when insufficient information is available to diagnose the presentation as another obsessive-compulsive and related disorder. Those obsessive-compulsive and related disorders that have a cognitive component (i.e., OCD, body dysmorphic disorder, and hoarding disorder) include a specifier for indicating the individual's degree of insight with respect to disorder-related beliefs, which ranges from "good or fair insight" to "poor insight" to "absent insight/delusional beliefs." Those individuals whose degree of insight is in the "absent insight/delusional beliefs" range should not be given an additional diagnosis of a psychotic disorder unless their delusional beliefs involve content that extends beyond what is characteristic of their obsessive-compulsive and related disorder (e.g., an individual with body dysmorphic disorder who is convinced that his or her food has been poisoned). Obsessive-Compulsive Disorder Diagnostic Criteria 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):
3. 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.
4. 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 (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in

substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder). Specify if: With good or fair insight: 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/delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true. Specify if: Tic-related: The individual has a current or past history of a tic disorder. Specifiers Individuals with obsessive-compulsive disorder (OCD) vary in the degree of insight they have about the accuracy of the beliefs that underlie their obsessive-compulsive symptoms. Many individuals have good or fair insight (e.g., the individual believes that the house definitely will not, probably will not, or may or may not burn down if the stove is not checked 30 times). Some

have poor insight (e.g., the individual believes that the house will probably burn down if the stove is not checked 30 times), and a few (4% or less) have absent insight/delusional beliefs (e.g., the individual is convinced that the house will burn down if the stove is not checked 30 times). Insight can vary within an individual over the course of the illness. Poorer insight has been linked to worse long-term outcome. Up to 30% of individuals with OCD have a lifetime tic disorder. This is most common in men with onset of OCD in childhood. These individuals tend to differ from those without a history of tic disorders in the themes of their OCD symptoms, comorbidity, course, and pattern of familial transmission. Diagnostic Features The characteristic symptoms of OCD are the presence of obsessions and compulsions (Criterion A). Obsessions are repetitive and persistent thoughts (e.g., of contamination), images (e.g., of violent or horrific scenes), or urges (e.g., to stab someone). Importantly, obsessions are not pleasurable or experienced as voluntary: they are intrusive and unwanted and cause marked distress or anxiety in most individuals. The individual attempts to ignore or suppress these obsessions (e.g., avoiding triggers or using thought suppression) or to neutralize them with another thought or action (e.g., performing a compulsion). Compulsions (or rituals) are repetitive behaviors (e.g., washing, checking) or mental acts (e.g., 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. Most individuals with OCD have both obsessions and compulsions. Obsessions and compulsions are typically thematically related (e.g., thoughts of contamination associated with washing rituals; thoughts of harm associated with repeated checking). Individuals often report that they perform compulsions to reduce the distress triggered by obsessions or to prevent a feared event (e.g., becoming ill). However, these compulsions either are not connected in a realistic way to the feared event (e.g., arranging items symmetrically to prevent harm to a loved one) or are clearly excessive (e.g., showering for hours each day). Compulsions are not done for pleasure, although individuals may experience temporary relief from anxiety or distress. The specific content of obsessions and compulsions varies between individuals. However, certain themes, or dimensions, are common, including those of cleaning (contamination obsessions and cleaning compulsions); symmetry (symmetry obsessions and repeating, ordering, and counting compulsions); forbidden or taboo thoughts (e.g., aggressive, sexual, or religious obsessions and related compulsions); and harm (e.g., fears of harm to self or others and checking compulsions). Some individuals also have difficulties discarding and accumulate objects as a consequence of typical obsessions and compulsions (e.g., fears of harming others); such

compulsions must be distinguished from the primary accumulation behaviors seen in hoarding disorder, discussed later in this chapter. These themes occur across different cultures, are relatively consistent over time in adults with the disorder, and may be associated with different neural substrates. Importantly, individuals often have symptoms in more than one dimension.

Criterion B emphasizes that obsessions and compulsions must be time-consuming (e.g., more than 1 hour per day) or cause clinically significant distress or impairment to warrant a diagnosis of OCD. This criterion helps to distinguish the disorder from the occasional intrusive thoughts or repetitive behaviors that are common in the general population (e.g., double-checking that a door is locked). The frequency and severity of obsessions and compulsions vary across individuals with OCD (e.g., some have mild to moderate symptoms, spending 1–3 hours per day obsessing or doing compulsions, whereas others have nearly constant intrusive thoughts or compulsions that can be incapacitating). Associated Features Sensory phenomena, defined as physical experiences (e.g., physical sensations, just-right sensations, and feelings of incompleteness) that precede compulsions, are common in OCD. Up to 60% of individuals with OCD report these phenomena. Individuals with OCD experience a range of affective responses when confronted with situations that trigger obsessions and compulsions. For example, many individuals experience marked anxiety that can include recurrent panic attacks. Others report strong feelings of disgust. While performing compulsions, some individuals report a distressing sense of “incompleteness” or uneasiness until things look, feel, or sound “just right.” It is common for individuals with the disorder to avoid people, places, and things that trigger obsessions and compulsions. For example, individuals with contamination concerns might avoid public situations (e.g., restaurants, public restrooms) to reduce exposure to feared contaminants; individuals with intrusive thoughts about causing harm might avoid social interactions. Many individuals with OCD have dysfunctional beliefs. These beliefs can include an inflated sense of responsibility and the tendency to overestimate threat; perfectionism and intolerance of uncertainty; and overimportance of thoughts (e.g., believing that having a forbidden thought is as bad as acting on it) and the need to control thoughts. These beliefs, however, are not specific to OCD. The involvement of family or friends in compulsive rituals, termed accommodation, can exacerbate or maintain symptoms and is an important target in treatment, especially in children. Prevalence The 12-month prevalence of OCD in the United States is 1.2%, with a similar prevalence internationally (including Canada, Puerto Rico, Germany, Taiwan, Korea, and New Zealand; 1.1%–1.8%). Women are affected at a slightly higher rate than men in adulthood, although men are more commonly affected in childhood. Development and Course In the United States, the mean age at onset of OCD is 19.5 years, and 25% of cases start by age 14 years. Onset after age 35 years is unusual but does occur. Men have an earlier age at onset than women: nearly 25% of men have onset before age 10 years. The onset of symptoms is typically gradual; however, acute onset can also occur. If OCD is untreated, the course is usually chronic, often with waxing and waning symptoms. Some individuals have an episodic course, and a minority have a deteriorating course. Without treatment, remission rates in adults are low (e.g., 20% for those reevaluated 40 years later). Onset

Temperamental. Environmental. Genetic and physiological. in childhood or adolescence can lead to a lifetime of OCD. However, 40% of individuals with onset of OCD in childhood or adolescence may experience remission by early adulthood. The course of OCD is often complicated by the cooccurrence of other disorders (see section “Comorbidity” for this disorder). Compulsions are more easily diagnosed in children than obsessions are because compulsions are usually

observable. However, most children have both obsessions and compulsions (as do most adults). The pattern of symptoms in adults can be stable over time, but it is more variable in children. Some differences in the content of obsessions and compulsions have been reported when children and adolescent samples are compared with adult samples. These differences likely reflect content appropriate to different developmental stages (e.g., higher rates of sexual and religious obsessions in adolescents than in children; higher rates of harm obsessions [e.g., fears of catastrophic events, such as death or illness to self or loved ones] in children and adolescents than in adults).

Risk and Prognostic Factors Greater internalizing symptoms, higher negative emotionality, and behavioral inhibition in childhood are possible temperamental risk factors. Different environmental factors may increase the risk for OCD. These include adverse perinatal events, premature birth, maternal tobacco use during pregnancy, physical and sexual abuse in childhood, and other stressful or traumatic events. Some children may develop the sudden onset of obsessive-compulsive symptoms, which has been associated with different environmental factors, including various infectious agents and a postinfectious autoimmune syndrome. The rate of OCD among first-degree relatives of adults with OCD is approximately two times that among first-degree relatives of those without the disorder; however, among first-degree relatives of individuals with onset of OCD in childhood or adolescence, the rate is increased 10-fold. Familial transmission is due in part to genetic factors (e.g., a concordance rate of 0.57 for monozygotic vs. 0.22 for dizygotic twins). Twin studies suggest that additive genetic effects account for ~40% of the variance in obsessive-compulsive symptoms. Dysfunction in the orbitofrontal cortex, anterior cingulate cortex, and striatum have been most strongly implicated; alterations in frontolimbic, frontoparietal, and cerebellar networks have also been reported.

Culture-Related Diagnostic Issues OCD occurs across the world. There is substantial similarity across cultures in the gender distribution, age at onset, and comorbidity of OCD. Moreover, around the globe, there is a similar symptom structure involving cleaning, symmetry, hoarding, taboo thoughts, and fear of harm. However, regional variation in symptom expression exists, and cultural factors may shape the content of obsessions and compulsions. For example, obsessions related to sexual content may be reported less frequently in some religious and cultural groups, and obsessions related to violence and aggression may be more common in settings with higher prevalence of urban

violence. Attributions of OCD symptoms vary cross-culturally, including physical, social, spiritual, and supernatural causes; specific compulsions and help-seeking options may be reinforced by these cultural attributions.

Sex- and Gender-Related Diagnostic Issues Men have an earlier age at onset of OCD than women, often in childhood, and are more likely to have comorbid tic disorders. Onset in girls is more typically in adolescence; among adults, OCD is slightly more common in women than in men. Gender differences in the pattern of symptom dimensions have been reported, with, for example, women more likely to have symptoms in the cleaning dimension and men more likely to have symptoms in the forbidden thoughts and symmetry dimensions. Onset or exacerbation of OCD, as well as symptoms that can interfere with the mother-infant relationship (e.g., aggressive obsessions such as intrusive violent thoughts of harming the infant, leading to avoidance of the infant), has been reported in the peripartum period. Some women also report exacerbation of OCD symptoms premenstrually.

Association With Suicidal Thoughts or Behavior A systematic literature review of suicidal ideation and suicide attempts in clinical samples with OCD from multiple countries found a mean rate of lifetime suicide attempts of 14.2%, a mean rate of lifetime suicidal ideation of 44.1%, and a mean rate of current suicidal ideation of 25.9%. Predictors of greater suicide risk were severity of OCD, the symptom dimension of unacceptable thoughts,

severity of comorbid depressive and anxiety symptoms, and past history of suicidality. Another international systematic review of 48 studies found a moderate to high significant association between suicidal ideation/suicide attempts and OCD. A cross-sectional study of 582 outpatients with OCD from Brazil found that 36% reported lifetime suicidal thoughts, 20% had made suicide plans, 11% had already attempted suicide, and 10% presented with current suicidal thoughts. The sexual/religious dimension of OCD and comorbid substance use disorders were associated with suicidal thoughts and suicide plans, impulse-control disorders were associated with current suicidal thoughts and with suicide plans and attempts, and lifetime comorbid major depressive disorder and posttraumatic stress disorder (PTSD) were associated with all aspects of suicidal behaviors. In a study using Swedish national registry data involving 36,788 individuals with OCD and matched general population control subjects, individuals with OCD had a higher risk of suicide death (OR = 9.8) and suicide attempt (OR = 5.5), and the increased risk for both outcomes remained substantial even after adjusting for psychiatric comorbidities. Comorbid personality or substance use disorder increased suicide risk, whereas female gender, higher parental education, and a comorbid anxiety disorder were protective factors. Functional Consequences of Obsessive-Compulsive Disorder OCD is associated with reduced quality of life as well as high levels of social and occupational impairment. Impairment occurs across many different domains of life and is associated with

Anxiety disorders. Major depressive disorder. Other obsessive-compulsive and related disorders. symptom severity. Impairment can be caused by the time spent obsessing and performing compulsions. Avoidance of situations that can trigger obsessions or compulsions can also severely impair functioning. In addition, specific symptoms can create specific obstacles. For example, obsessions about harm can make relationships with family and friends feel hazardous; the result can be avoidance of these relationships. Obsessions about symmetry can derail the timely completion of school or work projects because the project never feels “just right,” potentially resulting in school failure or job loss. Health consequences can also occur. For example, individuals with contamination concerns may avoid doctors’ offices and hospitals (e.g., because of fears of exposure to germs) or develop dermatological problems (e.g., skin lesions due to excessive washing). Sometimes the symptoms of the disorder interfere with its own treatment (e.g., when medications are considered contaminated). When the disorder starts in childhood or adolescence, individuals may experience developmental difficulties. For example, adolescents may avoid socializing with peers; young adults may struggle when they leave home to live independently. The result can be few significant relationships outside the family and a lack of autonomy and financial independence from their family of origin. In addition, some individuals with OCD try to impose rules and prohibitions on family members because of their obsessions (e.g., no one in the family can have visitors to the house for fear of contamination), and this can lead to family dysfunction. Differential Diagnosis Recurrent thoughts, avoidant behaviors, and repetitive requests for reassurance can also occur in anxiety disorders. However, the recurrent thoughts that are present in generalized anxiety disorder (i.e., worries) are usually about real-life concerns, whereas the obsessions of OCD usually do not involve real-life concerns and can include content that is odd, irrational, or of a seemingly magical nature; moreover, compulsions are usually present and usually linked to the obsessions. Like individuals with OCD, individuals with specific phobia can have a fear reaction to specific objects or situations; however, in specific phobia the feared object is usually much more circumscribed, and rituals are not present. In social anxiety disorder, the feared objects or situations are limited to social interactions or performance situations, and avoidance or reassurance seeking is focused on reducing feelings of embarrassment. OCD needs to be

distinguished from the rumination of major depressive disorder, in which thoughts are usually mood-congruent and not necessarily experienced as intrusive or distressing; moreover, ruminations are not linked to compulsions, as is typical in OCD. In body dysmorphic disorder, the obsessions and compulsions are limited to concerns about physical appearance; and in trichotillomania (hairpulling disorder), the compulsive behavior is limited to hair pulling in the absence of obsessions. Hoarding disorder symptoms focus exclusively on the persistent difficulty discarding or parting with possessions, marked distress associated with discarding items, and excessive accumulation of objects. However, if an individual has obsessions that are typical of OCD (e.g., concerns about

Eating disorders. Tics (in tic disorder) and stereotyped movements. Psychotic disorders. Other compulsive-like behaviors. Obsessive-compulsive personality disorder. incompleteness or harm), and these obsessions lead to compulsive accumulation (e.g., acquiring all objects in a set to attain a sense of completeness or not discarding old newspapers because they may contain information that could prevent harm), a diagnosis of OCD should be given instead. OCD can be distinguished from anorexia nervosa in that in OCD the obsessions and compulsions are not limited to concerns about weight and food. A tic is a sudden, rapid, recurrent, nonrhythmic motor movement or vocalization (e.g., eye blinking, throat clearing). A stereotyped movement is a repetitive, seemingly driven, nonfunctional motor behavior (e.g., head banging, body rocking, self-biting). Tics and stereotyped movements are typically less complex than compulsions and are not aimed at neutralizing obsessions. However, distinguishing between complex tics and compulsions can be difficult. Whereas compulsions are usually preceded by obsessions, tics are often preceded by premonitory sensory urges. Some individuals have symptoms of both OCD and a tic disorder, in which case both diagnoses may be warranted. Some individuals with OCD have poor insight or even delusional OCD beliefs. However, they have obsessions and compulsions (distinguishing their condition from delusional disorder) and do not have other features of schizophrenia or schizoaffective disorder (e.g., hallucinations or disorganized speech). For individuals whose OCD symptoms warrant the “with absent insight/delusional beliefs” specifier, these symptoms should not be diagnosed as a psychotic disorder. Certain behaviors are sometimes described as “compulsive,” including sexual behavior (in the case of paraphilias), gambling (i.e., gambling disorder), and substance use (e.g., alcohol use disorder). However, these behaviors differ from the compulsions of OCD in that the person usually derives pleasure from the activity and may wish to resist it only because of its deleterious consequences. Although obsessive-compulsive personality disorder and OCD have similar names, the clinical manifestations of these disorders are quite different. Obsessive-compulsive personality disorder is not characterized by intrusive thoughts, images, or urges or by repetitive behaviors that are performed in response to these intrusive symptoms; instead, it involves an enduring and pervasive maladaptive pattern of excessive perfectionism and rigid control. If an individual manifests symptoms of both OCD and obsessive-compulsive personality disorder, both diagnoses can be given. Comorbidity Individuals with OCD often have other psychopathology. Many adults with the disorder in the United States have a lifetime diagnosis of an anxiety disorder (76%; e.g., panic disorder, social anxiety disorder, generalized anxiety disorder, specific phobia) or a depressive or bipolar disorder (63% for any depressive or bipolar disorder, with the most common being major depressive disorder [41%]); a lifetime diagnosis of an impulse-control disorder (56%) or a substance use disorder (39%) is also common. Onset of OCD is usually later than for most

F45.22 comorbid anxiety disorders (with the exception of separation anxiety disorder) and PTSD but often precedes that of depressive disorders. In a study of 214 treatment-seeking adults in the United States with DSM-IV OCD at intake, comorbid obsessive-compulsive personality disorder was found in 23%–32% of individuals followed longitudinally. Up to 30% of individuals with OCD also have a lifetime tic disorder. A comorbid tic disorder is most common in men with onset of OCD in childhood. These individuals tend to differ from those without a history of tic disorders in the themes of their OCD symptoms, comorbidity, course, and pattern of familial transmission. A triad of OCD, tic disorder, and attention deficit/hyperactivity disorder can also be seen in children. Several obsessive-compulsive and related disorders, including body dysmorphic disorder, trichotillomania, and excoriation (skin-picking) disorder, also occur more frequently in individuals with OCD than in those without OCD. OCD is also much more common in individuals with certain other disorders than would be expected based on its prevalence in the general population; when one of those other disorders is diagnosed, the individual should be assessed for OCD as well. For example, in individuals with schizophrenia or schizoaffective disorder, the prevalence of OCD is approximately 12%. Rates of OCD are also elevated in bipolar disorder; eating disorders, such as anorexia nervosa and bulimia nervosa; body dysmorphic disorder; and Tourette's disorder. Body Dysmorphic Disorder Diagnostic Criteria 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 look 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/delusional beliefs: The individual is completely convinced that the body dysmorphic disorder beliefs are true. Specifiers Muscle dysmorphia, a form of body dysmorphic disorder occurring almost exclusively in men and adolescent boys, consists of preoccupation with the idea that one's body is too small or insufficiently lean or muscular. Individuals with this form of the disorder actually have a normal-looking body or are even very muscular. They may also be preoccupied with other body areas, such as skin or hair. A majority (but not all) diet, exercise, and/or lift weights excessively, sometimes causing bodily damage. Some use potentially dangerous anabolic-androgenic steroids and other substances to try to make their body bigger and more muscular. Individuals with body dysmorphic disorder vary in the degree of insight they have about the accuracy of their body dysmorphic disorder beliefs (e.g., "I look ugly," "I look deformed"). Insight regarding body dysmorphic disorder beliefs can range from good to absent/delusional (i.e., delusional beliefs consisting of complete conviction that the individual's view of his or her appearance is accurate and undistorted). On average, insight is poor, and one-third or more of individuals currently have absent insight/delusional body dysmorphic disorder beliefs. Individuals

with delusional body dysmorphic disorder tend to have greater morbidity in some areas (e.g., suicidal thoughts or behavior), but this appears to be accounted for by their tendency to have more severe body dysmorphic disorder symptoms. Diagnostic Features Individuals with body dysmorphic disorder (formerly known as dysmorphophobia) are preoccupied with one or more perceived defects or flaws in their physical appearance, which they believe look ugly, unattractive, abnormal, or deformed (Criterion A). The perceived flaws are not observable or appear only slight to other individuals. Concerns range from looking “unattractive” or “not right” to looking “hideous” or “like a monster.” Preoccupations can focus on one or many body areas, most commonly the skin (e.g., perceived acne, scars, lines, wrinkles, paleness), hair (e.g., “thinning” hair or “excessive” body or facial hair), or nose (e.g., size or shape). However, any body area can be the focus of concern (e.g., eyes, teeth, weight, stomach, breasts, legs, face size or shape, lips, chin, eyebrows, genitals). Some individuals are concerned about perceived asymmetry of body areas. The preoccupations are intrusive, unwanted, timeconsuming (occurring, on average, 3–8 hours per day), and usually difficult to resist or control. Excessive repetitive behaviors or mental acts (e.g., comparing) are performed in response to

the preoccupation (Criterion B). The individual feels driven to perform these behaviors, which are not pleasurable and may increase anxiety and dysphoria. They are typically time-consuming and difficult to resist or control. Common behaviors are comparing one’s appearance with that of other individuals; repeatedly checking perceived defects in mirrors or other reflecting surfaces or examining them directly; taking excessive “selfies”; excessively grooming (e.g., combing, styling, shaving, plucking or pulling hair); seeking reassurance about how the perceived flaws look; touching disliked areas to check them; excessively exercising or weight lifting; and seeking cosmetic procedures. Some individuals excessively tan (e.g., to darken “pale” skin or diminish perceived acne), repeatedly change their clothes (e.g., to camouflage perceived defects), or compulsively shop (e.g., for beauty products). Compulsive skin picking intended to improve perceived skin defects is common and can cause skin damage, infections, or ruptured blood vessels. Camouflaging (i.e., hiding or covering) perceived defects, a very common behavior in individuals with body dysmorphic disorder, may involve repetitive behaviors (e.g., repeatedly applying makeup, adjusting a hat or clothing, rearranging head hair to cover the forehead or eyes). The preoccupation must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C); usually both are present. Body dysmorphic disorder must be differentiated from an eating disorder. Body dysmorphic disorder by proxy is a form of body dysmorphic disorder in which individuals are preoccupied with defects they perceive in another person’s appearance, most often a significant other (e.g., spouse or partner), but sometimes a parent, child, sibling, or stranger. Associated Features Many individuals with body dysmorphic disorder have ideas or delusions of reference, believing that other people take special notice of them or mock them because of how they look. Body dysmorphic disorder is associated with high levels of anxiety, social anxiety, social avoidance, depressed mood, negative affectivity (neuroticism), rejection sensitivity, and perfectionism as well as low extroversion and low self-esteem. Body dysmorphic disorder is also associated with elevated hostility and aggressive behavior. Many individuals are ashamed of their appearance and their excessive focus on how they look and are reluctant to reveal their concerns to others. A majority of individuals receive cosmetic treatment to try to improve their perceived defects. Dermatological treatment and surgery are most common, but any type (e.g., dental, electrolysis) may be received. Some individuals perform surgery on themselves. Body dysmorphic disorder appears to respond poorly to such treatments

and sometimes becomes worse. Some individuals take legal action or are violent toward the clinician (e.g., surgeon) because they are dissatisfied with the cosmetic outcome. Body dysmorphic disorder has been associated with abnormalities in emotion recognition, attention, and executive function, as well as information-processing biases and inaccuracies in interpretation of information and social situations. For example, individuals with this disorder tend to have a bias for negative and threatening interpretations of facial expressions and ambiguous scenarios. Body dysmorphic disorder is also characterized by visual processing abnormalities, with a bias for analyzing and encoding details rather than holistic or configural

Environmental. Genetic and physiological. aspects of visual stimuli. Prevalence The point prevalence in a nationwide epidemiological study among U.S. adults was 2.4% (2.5% in women and 2.2% in men). Outside the United States (e.g., Germany), similar studies indicate that the point prevalence is 1.7%–2.9%, with a gender distribution similar to that in the United States. Globally, the point prevalence is 11%–13% among dermatology patients, 13%–15% among general cosmetic surgery patients, 20% in rhinoplasty surgery patients, 11% among adult jaw correction surgery patients, and 5%–10% among adult orthodontia/cosmetic dentistry patients. Among adolescents and college students, point prevalence rates are relatively higher in girls/young women compared with boys/young men. **Development and Course** The mean age at disorder onset is 16–17 years, the median age at onset is 15 years, and the most common age at onset is 12–13 years; in two-thirds of individuals, onset is before age 18. Subclinical body dysmorphic disorder symptoms begin, on average, at age 12 or 13 years. Subclinical concerns usually evolve gradually to the full disorder, although some individuals experience abrupt onset of body dysmorphic disorder. The disorder appears to usually be chronic, although improvement is likely when evidence-based treatment is received. The disorder's clinical features appear largely similar in children/adolescents and adults. Body dysmorphic disorder occurs in the elderly, but little is known about the disorder in this age group. Individuals with disorder onset before age 18 years have more comorbidity and are more likely to have gradual (rather than acute) disorder onset than those with adult-onset body dysmorphic disorder. **Risk and Prognostic Factors** Body dysmorphic disorder has been associated with high rates of childhood neglect, abuse, and trauma, as well as elevated rates of teasing. The prevalence of body dysmorphic disorder is elevated in first-degree relatives of individuals with obsessive-compulsive disorder (OCD). Heritability of body dysmorphic disorder symptoms is estimated at 37%–49% in studies of adolescent and young adult twins and may be higher in women. There is shared genetic vulnerability with OCD as well as genetic influences that are specific to body dysmorphic disorder symptoms. **Culture-Related Diagnostic Issues** Body dysmorphic disorder has been reported internationally. Certain features of the disorder appear cross-culturally, such as gender ratio, body areas that are the object of concern, types of repetitive behaviors, and levels of associated distress and impairment. Other features may vary (e.g., in some cultural contexts with a collectivistic focus, such as Japan, body dysmorphic concerns might emphasize the fear of offending others because of the perceived deformity). Varying cultural standards may be associated with specific body image concerns, such as

eyelids in Japan and muscle dysmorphia in Western countries. Taijin kyofusho, included in the traditional Japanese diagnostic system, has a subtype similar to body dysmorphic disorder: shubokyofu (“the phobia of a deformed body”). For more information regarding cultural concepts of distress, refer to the “Culture and Psychiatric Diagnosis” chapter. **Sex- and Gender-Related Diagnostic Issues** Muscle dysmorphia occurs almost exclusively in men, and men are more likely to

have a comorbid substance use disorder, whereas women are more likely to have a comorbid eating disorder. Women and men appear to have more similarities than differences in terms of most clinical features—for example, disliked body areas, types of repetitive behaviors, symptom severity, suicidality, comorbidity, illness course, and receipt of cosmetic procedures for body dysmorphic disorder. However, there are some differences. For example, men are more likely to have preoccupations with their genitals, body build (thinking they are too small or inadequately muscular), and thinning hair, whereas women are more likely to be preoccupied with weight (usually thinking that they weigh too much), breasts/chest, buttocks, legs, hips, and excessive body/facial hair.

Association With Suicidal Thoughts or Behavior In a systematic review and meta-analysis of 17 studies that examined suicidal thoughts and behaviors across several countries, individuals with body dysmorphic disorder were four times more likely to have experienced suicidal thoughts (pooled OR = 3.87) and 2.6 times more likely to have made suicide attempts (pooled OR = 2.57) when compared with healthy control subjects and individuals diagnosed with eating disorders, OCD, or any anxiety disorder. Two general population studies in Germany found higher rates of suicidal thoughts—19% vs. 3%; 31.0% vs. 3.5%—and behaviors—7% vs. 1%; 22.2% vs. 2.1%—in individuals diagnosed with body dysmorphic disorder than in those without the diagnosis. Severity of body dysmorphic disorder strengthens the association of body dysmorphic disorder with suicidal thoughts and behaviors. The relationship between body dysmorphic disorder and elevated suicidal thoughts and behaviors is independent of comorbidity, but certain comorbidities may further strengthen this relationship. A substantial proportion of individuals with body dysmorphic disorder attribute suicidal thoughts or suicide attempts primarily to their appearance concerns. Individuals with body dysmorphic disorder have many demographic and clinical risk factors that more generally predict suicide death, such as high rates of suicidal thoughts and suicide attempts, unemployment, perceived abuse, poor self-esteem, and high rates of comorbid major depressive disorder, eating disorders, and substance use disorders.

Functional Consequences of Body Dysmorphic Disorder Nearly all individuals with body dysmorphic disorder experience impaired psychosocial functioning because of their appearance concerns. Impairment can range from moderate (e.g., avoidance of some social situations) to extreme and incapacitating (e.g., being completely

Normal appearance concerns and clearly noticeable physical defects. Eating disorders. Other obsessive-compulsive and related disorders. Illness anxiety disorder. Major depressive disorder. Anxiety disorders. housebound). On average, psychosocial functioning and quality of life are markedly poor. More severe body dysmorphic disorder symptoms are associated with poorer functioning and quality of life. Most individuals experience impairment in their job, academic, or role functioning (e.g., as a parent or caregiver), which is often severe (e.g., performing poorly, missing school or work, not working). About 20% of youths with body dysmorphic disorder report dropping out of school primarily because of their body dysmorphic disorder symptoms. A high proportion of adults and adolescents have been psychiatrically hospitalized.

Differential Diagnosis Body dysmorphic disorder differs from normal appearance concerns in being characterized by excessive appearance-related preoccupations and repetitive behaviors that are time-consuming, are usually difficult to resist or control, and cause clinically significant distress or impairment in functioning. Physical defects that are clearly noticeable (i.e., not slight) are not diagnosed as body dysmorphic disorder. However, skin picking as a symptom of body dysmorphic disorder can cause noticeable skin lesions and scarring; in such cases, body dysmorphic disorder should be diagnosed. In an individual with an eating disorder, concerns about being fat or overweight are considered a

symptom of the eating disorder rather than body dysmorphic disorder. However, weight concerns may occur in body dysmorphic disorder. Eating disorders and body dysmorphic disorder can be comorbid, in which case both should be diagnosed. The preoccupations and repetitive behaviors of body dysmorphic disorder differ from obsessions and compulsions in OCD in that the former focus only on physical appearance. These disorders have other differences, such as poorer insight, more frequent depression, and higher rates of suicidal ideation in body dysmorphic disorder. When skin picking is intended to improve the appearance of perceived skin defects, body dysmorphic disorder, rather than excoriation (skin-picking) disorder, is diagnosed. When hair removal (plucking, pulling, or other types of removal) is intended to improve perceived defects in the appearance of facial, head, or body hair, body dysmorphic disorder is diagnosed rather than trichotillomania (hair-pulling disorder). Individuals with body dysmorphic disorder are not preoccupied with having or acquiring a serious illness and in clinical samples do not have particularly elevated levels of somatization. The prominent preoccupation with appearance and excessive repetitive behaviors in body dysmorphic disorder differentiate it from major depressive disorder. However, major depressive disorder and depressive symptoms are common in individuals with body dysmorphic disorder, often appearing to be secondary to the distress and impairment that body dysmorphic disorder causes. Body dysmorphic disorder should be diagnosed in depressed individuals if diagnostic criteria for body dysmorphic disorder are met. Social anxiety and avoidance are common in body dysmorphic disorder.

Psychotic disorders. Other disorders and symptoms. However, unlike social anxiety disorder, agoraphobia, and avoidant personality disorder, body dysmorphic disorder includes prominent appearance-related preoccupation, which may be delusional, and repetitive behaviors. In addition, the social anxiety and avoidance that are characteristic of body dysmorphic disorder are attributable to concerns about perceived appearance defects and the belief or fear that other people will consider these individuals ugly, ridicule them, or reject them because of their physical features. Unlike generalized anxiety disorder, anxiety and worry in body dysmorphic disorder focus on perceived appearance flaws. Many individuals with body dysmorphic disorder have delusional appearance beliefs (i.e., complete conviction that their view of their perceived defects is accurate), which is diagnosed as body dysmorphic disorder, with absent insight/delusional beliefs, not as delusional disorder. Appearance-related ideas or delusions of reference are common in body dysmorphic disorder (i.e., thinking that other people take special notice in a negative way because of the individual's appearance). However, unlike schizophrenia or schizoaffective disorder, body dysmorphic disorder involves prominent appearance preoccupations and related repetitive behaviors; disorganized behavior and other psychotic symptoms are absent (except for appearance beliefs, which may be delusional). For individuals whose obsessive-compulsive and related disorder symptoms warrant the "with absent insight/delusional beliefs" specifier, these symptoms should not be diagnosed as a psychotic disorder. Body dysmorphic disorder should not be diagnosed if the preoccupation is limited to discomfort with or a desire to be rid of one's primary and/or secondary sex characteristics in an individual with gender dysphoria. Nor should body dysmorphic disorder be diagnosed if the preoccupation focuses on the belief that one emits a foul or offensive body odor as in olfactory reference disorder (olfactory reference syndrome), which is an example of an other specified obsessive-compulsive and related disorder in DSM-5. Body integrity dysphoria (which is included in ICD-11 but not DSM-5) involves a persistent desire to become an amputee in order to correct a mismatch between the individual's sense of how his or her body should be configured and his or her actual anatomical configuration. In contrast to body dysmorphic disorder, the individual

does not feel that the limb to be amputated is ugly or defective in any way, just that it should not be there. Koro, a culturally related disorder that usually occurs in epidemics in Southeastern Asia, consists of a fear that the penis (labia, nipples, or breasts in females) is shrinking or retracting and will disappear into the abdomen, often accompanied by a belief that death will result. Koro differs from body dysmorphic disorder in several ways, including a focus on death rather than preoccupation with perceived ugliness. Dysmorphic concern (which is not a DSM-5 disorder) is a broader construct that is similar to, but not equivalent to, body dysmorphic disorder. It involves symptoms reflecting an overconcern with slight or imagined flaws in appearance. Comorbidity Major depressive disorder is the most common comorbid disorder, with onset usually after that

F42.3 of body dysmorphic disorder. Comorbid social anxiety disorder, OCD, and substance-related disorders (including use of anabolic-androgenic steroids in the muscle dysmorphia form of body dysmorphic disorder) are also common. Hoarding Disorder Diagnostic Criteria 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/delusional 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.

With excessive acquisition. Specifiers Approximately 80%–90% of individuals with hoarding disorder display excessive acquisition. The most frequent form of acquisition is excessive buying, followed by acquisition of free items (e.g., leaflets, items discarded by others). Stealing is less common. Some individuals may deny excessive acquisition when first assessed, yet it may appear later during the course of treatment. Individuals with hoarding disorder typically experience distress if they are unable to or are prevented from acquiring items. Diagnostic Features The essential feature of hoarding disorder is persistent difficulty discarding or parting with possessions, regardless of their actual value (Criterion A). The term persistent indicates a longstanding difficulty rather than more transient life circumstances that may lead to excessive clutter, such as inheriting property. The difficulty in discarding possessions noted in Criterion A refers to any form of

discarding, including throwing away, selling, giving away, or recycling. The main reasons given for this difficulty are the perceived utility or aesthetic value of the items or strong sentimental attachment to the possessions. Some individuals feel responsible for the fate of their possessions and often go to great lengths to avoid being wasteful. Fears of losing important information are also common. The most commonly saved items are newspapers, magazines, clothing, bags, books, mail, and papers, but virtually any item can be saved. The nature of items is not limited to possessions that most other people would define as useless or of limited value. Many individuals collect and save large numbers of valuable things as well, which are often found in piles mixed with other less valuable items. Individuals with hoarding disorder purposefully save possessions and experience distress (e.g., anxiety, frustration, regret, sadness, guilt) when facing the prospect of discarding them (Criterion B). This criterion emphasizes that the saving of possessions is intentional, which discriminates hoarding disorder from other forms of psychopathology that are characterized by the passive accumulation of items or the absence of distress when possessions are removed. Individuals accumulate large numbers of items that fill up and clutter active living areas to the extent that their intended use is no longer possible (Criterion C). For example, the individual may not be able to cook in the kitchen, sleep in his or her bed, or sit in a chair. If the space can be used, it is only with great difficulty. Clutter is defined as a large group of usually unrelated or marginally related objects piled together in a disorganized fashion in spaces designed for other purposes (e.g., tabletops, floor, hallway). Criterion C emphasizes the “active” living areas of the home, rather than more peripheral areas, such as garages, attics, or basements, that are sometimes cluttered in homes of individuals without hoarding disorder. However, individuals with hoarding disorder often have possessions that spill beyond the active living areas and can occupy and impair the use of other spaces, such as vehicles, yards, the workplace, and friends’ and relatives’ houses. In some cases, living areas may be uncluttered only because of the intervention of third parties (e.g., family members, cleaners, local authorities). Individuals who have been forced to clear their homes still have a symptom picture that meets criteria for hoarding disorder because

the lack of clutter is attributable to a third-party intervention. Hoarding disorder contrasts with normative collecting behavior, which is organized and selective, although in some cases the actual amount of possessions may be similar to the amount accumulated by an individual with hoarding disorder. Normative collecting does not produce the clutter, distress, or impairment typical of hoarding disorder. Symptoms (i.e., difficulty discarding and/or clutter) must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, including maintaining a safe environment for self and others (Criterion D). In some cases, particularly when there is poor insight, the individual may not report distress, and the impairment may be apparent only to those around the individual. However, any attempts to discard or clear the possessions by third parties result in high levels of distress. Associated Features Other common features of hoarding disorder include indecisiveness, perfectionism, avoidance, procrastination, difficulty planning and organizing tasks, and distractibility. Some individuals with hoarding disorder live in unsanitary conditions that may be a logical consequence of severely cluttered spaces and/or that are related to planning and organizing difficulties. Animal hoarding can be defined as the accumulation of a large number of animals and a failure to provide minimal standards of nutrition, sanitation, and veterinary care, as well as failure to act on the deteriorating condition of the animals (including disease, starvation, or death) and the environment (e.g., severe overcrowding, extremely unsanitary conditions). Animal hoarding may be a special manifestation of hoarding

disorder. Many individuals who hoard animals also hoard inanimate objects. The most prominent differences between animal and object hoarding are the extent of unsanitary conditions and the poorer insight in animal hoarding. Prevalence Nationally representative prevalence studies of hoarding disorder are not available. Community surveys estimate the point prevalence of clinically significant hoarding in the United States and Europe to range between 1.5% and 6%. In a meta-analysis of 12 studies across high-income countries, a prevalence of 2.5% was found, with no gender difference identified. This contrasts with clinical samples, which are predominantly women. In one population-based study in the Netherlands, hoarding symptoms appeared to be almost three times more prevalent in older adults (older than 65 years) compared with younger adults (ages 30–40 years). Development and Course Hoarding appears to begin early in life and spans well into the late stages. Hoarding symptoms may first emerge around ages 15–19 years, start interfering with the individual's everyday functioning by the mid-20s, and cause clinically significant impairment by the mid-30s. Participants in clinical research studies are usually in their 50s. Thus, the severity of hoarding increases with each decade of life, especially after age 30. Once symptoms begin, the course of hoarding is often chronic, with few individuals reporting a waxing and waning course.

Temperamental. Environmental. Genetic and physiological. Pathological hoarding in children appears to be easily distinguished from developmentally adaptive saving and collecting behaviors. Because children and adolescents typically do not control their living environment and discarding behaviors, the possible intervention of third parties (e.g., parents keeping the spaces usable and thus reducing interference) should be considered when making the diagnosis. Risk and Prognostic Factors Indecisiveness is a prominent feature of individuals with hoarding disorder and their first-degree relatives. Individuals with hoarding disorder often retrospectively report stressful and traumatic life events preceding the onset of the disorder or causing an exacerbation. Hoarding behavior is familial; more than 50% of individuals who hoard report having a relative who also hoards. Twin studies indicate that approximately 50% of the variability in hoarding behavior is attributable to additive genetic factors and the rest to nonshared environmental factors. Culture-Related Diagnostic Issues While most of the research has been done in Western, industrialized countries and urban communities, the available data from low- and middle-income countries suggest that hoarding has consistent clinical features cross-culturally, including similarities in severity at clinical presentation and associated cognitions and behaviors. In cultural contexts in which a high value is placed on thrift and storing of possessions, the presence of distress and functional impairment should be the basis for the diagnosis. Sex- and Gender-Related Diagnostic Issues The key features of hoarding disorder (i.e., difficulty discarding, excessive amount of clutter) are generally comparable in men and women, but women tend to display more excessive acquisition, particularly excessive buying, than do men. Functional Consequences of Hoarding Disorder Clutter impairs basic activities, such as moving through the house, cooking, cleaning, maintaining personal hygiene, and even sleeping. Appliances may be broken, and utilities such as water and electricity may be disconnected, as access for repair work may be difficult. Quality of life is often considerably impaired. In severe cases, hoarding can put individuals at risk for fire, falling (especially elderly individuals), poor sanitation, and other health risks. Hoarding disorder is associated with occupational impairment, poor physical health, and high social service utilization. Family relationships are frequently under great strain. Conflict with neighbors and local authorities is common, and a substantial proportion of individuals with severe hoarding disorder have been involved in legal eviction proceedings, and some have a history of eviction. Differential Diagnosis

Other medical conditions. Neurodevelopmental disorders. Schizophrenia spectrum and other psychotic disorders. Major depressive episode. Obsessive-compulsive disorder. Neurocognitive disorders. Hoarding disorder is not diagnosed if the symptoms are judged to be a direct consequence of another medical condition (Criterion E), such as traumatic brain injury, surgical resection for treatment of a tumor or seizure control, cerebrovascular disease, infections of the central nervous system (e.g., herpes simplex encephalitis), or neurogenetic conditions such as Prader-Willi syndrome. Damage to the anterior ventromedial prefrontal and cingulate cortices has been particularly associated with the excessive accumulation of objects. In these individuals, the hoarding behavior is not present prior to the onset of the brain damage and appears shortly after the brain damage occurs. Some of these individuals appear to have little interest in the accumulated items and are able to discard them easily or do not care if others discard them, whereas others appear to be very reluctant to discard anything. Hoarding disorder is not diagnosed if the accumulation of objects is judged to be a direct consequence of a neurodevelopmental disorder, such as autism spectrum disorder or intellectual developmental disorder (intellectual disability). Hoarding disorder is not diagnosed if the accumulation of objects is judged to be a direct consequence of delusions or negative symptoms in schizophrenia spectrum and other psychotic disorders. Hoarding disorder is not diagnosed if the accumulation of objects is judged to be a direct consequence of psychomotor retardation, fatigue, or loss of energy during a major depressive episode. Hoarding disorder is not diagnosed if the symptoms are judged to be a direct consequence of typical obsessions or compulsions, such as fears of contamination, harm, or feelings of incompleteness in obsessive-compulsive disorder (OCD). Feelings of incompleteness (e.g., losing one's identity, or having to document and preserve all life experiences) are the most frequent OCD symptoms associated with this form of hoarding. The accumulation of objects can also be the result of persistently avoiding onerous rituals (e.g., not discarding objects in order to avoid endless washing or checking rituals). In OCD, the behavior is generally unwanted and highly distressing, and the individual experiences no pleasure or reward from it. Excessive acquisition is usually not present; if excessive acquisition is present, items are acquired because of a specific obsession (e.g., the need to buy items that have been accidentally touched in order to avoid contaminating other people), not because of a genuine desire to possess the items. Individuals who hoard in the context of OCD are also more likely to accumulate bizarre items, such as trash, feces, urine, fingernail and toenail cuttings, hair, used diapers, or rotten food. Accumulation of such items is very unusual in hoarding disorder. When severe hoarding appears concurrently with other typical symptoms of OCD but is judged to be independent from these symptoms, both hoarding disorder and OCD may be diagnosed. Hoarding disorder is not diagnosed if the accumulation of objects is judged to be a direct consequence of a degenerative disorder, such as neurocognitive disorder associated with frontotemporal degeneration or Alzheimer's disease. Typically, onset of the accumulating behavior is gradual and follows onset of the neurocognitive disorder. The

F63.3 accumulating behavior may be accompanied by self-neglect and severe domestic squalor, alongside other neuropsychiatric symptoms, such as disinhibition, gambling, rituals/stereotypies, tics, and self-injurious behaviors. Comorbidity Approximately 75% of individuals with hoarding disorder have a comorbid mood or anxiety disorder. The most common comorbid conditions are major depressive disorder (30%–50%), social anxiety disorder, and generalized anxiety disorder. Approximately 20% of individuals with hoarding disorder also have symptoms that meet diagnostic criteria for OCD. These comorbidities may often be the main reason for consultation, because individuals are unlikely to spontaneously report hoarding symptoms, and hoarding symptoms are

often not asked about in routine clinical interviews. Trichotillomania (Hair-Pulling Disorder)

Diagnostic Criteria 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).

Diagnostic Features The essential feature of trichotillomania (hair-pulling disorder) is the recurrent pulling out of one's own hair (Criterion A). Hair pulling may occur from any region of the body in which hair grows; the most common sites are the scalp, eyebrows, and eyelids, while less common sites are axillary, facial, pubic, and perirectal regions. Hair-pulling sites may vary over time. Hair pulling may occur in brief episodes scattered throughout the day or during less frequent but more sustained periods that can continue for hours, and such hair pulling may endure for months or years. Criterion A requires that hair pulling lead to hair loss, although individuals with this disorder may pull hair in a widely distributed pattern (i.e., pulling single hairs from all over a site) such that hair loss may not be clearly visible. In addition, individuals may attempt to conceal or camouflage hair loss (e.g., by using makeup, scarves, or wigs).

Individuals with trichotillomania have made repeated attempts to decrease or stop hair pulling (Criterion B). Criterion C indicates that hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. The term distress includes negative affects that may be experienced by individuals with hair pulling, such as feeling a loss of control, embarrassment, and shame. Significant impairment may occur in several different areas of functioning (e.g., social, occupational, academic, and leisure), in part because of avoidance of work, school, or other public situations.

Associated Features Hair pulling may be accompanied by a range of behaviors or rituals involving hair. Thus, individuals may search for a particular kind of hair to pull (e.g., hairs with a specific texture or color), may try to pull out hair in a specific way (e.g., so that the root comes out intact), or may visually examine or tactilely or orally manipulate the hair after it has been pulled (e.g., rolling the hair between the fingers, pulling the strand between the teeth, biting the hair into pieces, or swallowing the hair). Hair pulling may also be preceded or accompanied by various emotional states; it may be triggered by feelings of anxiety or boredom, may be preceded by an increasing sense of tension (either immediately before pulling out the hair or when attempting to resist the urge to pull), or may lead to gratification, pleasure, or a sense of relief when the hair is pulled out. Hair-pulling behavior may involve varying degrees of conscious awareness, with some individuals displaying more focused attention on the hair pulling (with preceding tension and subsequent relief), and other individuals displaying more automatic behavior (in which the hair pulling seems to occur without full awareness). Many individuals report a mix of both behavioral styles. Some individuals experience an "itch-like" or tingling sensation in the scalp that is alleviated by the act of pulling hair. Pain does not usually accompany hair pulling. Patterns of hair loss are highly variable. Areas of complete alopecia, as well as areas of thinned hair density, are common. When the scalp is involved, there may be a predilection for pulling out hair in the crown or parietal regions. There may be a pattern of nearly complete baldness except for a narrow perimeter around the outer margins of the scalp, particularly at the nape of the neck ("tonsure trichotillomania"). Eyebrows and eyelashes may be completely absent. Hair pulling does not usually occur in the presence of other individuals, except immediate family members. Some individuals have urges to pull hair from other individuals and

may sometimes try to find opportunities to do so surreptitiously. Some individuals may pull hairs from pets, dolls, and other fibrous materials (e.g., sweaters or carpets). Some individuals may deny their hair pulling to others. The majority of individuals with trichotillomania also have one or more other body-focused repetitive behaviors, including skin picking, nail biting, and lip chewing.

Prevalence In the general population, data from nonrepresentative U.S. samples have suggested that the 12-month prevalence estimate for trichotillomania in adults and adolescents may be in

Genetic and physiological. the range of 1% to 2%. Women are more frequently affected than men in self-identified or clinical samples, at a ratio estimated at 10:1 or greater, but the gender ratio may be closer to 2:1 in community samples. Among children with trichotillomania, boys and girls are more equally represented. An online survey of more than 10,000 adults ages 18–69 years, representative of the general U.S. population, found that 1.7% identified as having current trichotillomania and that rates did not differ significantly based on gender (1.8% of men and 1.7% of women).

Development and Course Hair pulling may be seen in infants, and this behavior typically resolves during early development. Onset of hair pulling in trichotillomania most commonly coincides with, or follows the onset of, puberty. Sites of hair pulling may vary over time. The usual course of trichotillomania is chronic, with some waxing and waning if the disorder is untreated. Symptoms may worsen in females premenstrually but not consistently during pregnancy. For some individuals, the disorder may come and go for weeks, months, or years at a time. A minority of individuals remit without subsequent relapse within a few years of onset.

Risk and Prognostic Factors There is evidence for a genetic vulnerability to trichotillomania. The disorder is more common in individuals with obsessive-compulsive disorder (OCD) and their first-degree relatives than in the general population.

Culture-Related Diagnostic Issues Trichotillomania appears to manifest similarly across cultures and ethnicities, although there is a paucity of data from non-Western regions.

Diagnostic Markers Most individuals with trichotillomania admit to hair pulling; thus, dermatopathological diagnosis is rarely required. Skin biopsy and dermoscopy (or trichoscopy) of trichotillomania are able to differentiate the disorder from other causes of alopecia. In trichotillomania, dermoscopy shows a range of characteristic features, including decreased hair density, short vellus hair, and broken hairs with different shaft lengths.

Functional Consequences of Trichotillomania (Hair-Pulling 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 resulting from hair biting). Swallowing of hair (trichophagia) may lead to trichobezoars, with subsequent anemia, abdominal pain, hematemesis, nausea and vomiting, bowel obstruction, and even bowel perforation.

Differential Diagnosis

Normative hair removal/manipulation. Other obsessive-compulsive and related disorders. Stereotypic movement disorder. Psychotic disorder. Another medical condition. Substance-related disorders.

F42.4 Trichotillomania should not be diagnosed when hair removal is performed solely for cosmetic reasons (i.e., to improve physical appearance). Many individuals twist and play with their hair, but this behavior does not usually qualify for a diagnosis of trichotillomania. Some individuals may bite rather than pull hair; again, this does not qualify for a diagnosis of trichotillomania. Individuals with OCD and symmetry concerns may pull out hairs as part of their symmetry rituals, and individuals with body dysmorphic disorder may remove body hair that they perceive as ugly, asymmetrical, or abnormal; in such cases a diagnosis of trichotillomania is not

given. Stereotypic movement disorder can sometimes involve hairpulling behavior. For example, a child with intellectual developmental disorder (intellectual disability) or autism spectrum disorder may engage in stereotypic head banging, hand or arm biting, and hair pulling when frustrated or angry, and sometimes when excited. This behavior, if impairing, would be diagnosed as stereotypic movement disorder (co-occurring with intellectual developmental disorder or autism spectrum disorder) rather than trichotillomania. Individuals with a psychotic disorder may remove hair in response to a delusion or hallucination. Trichotillomania is not diagnosed in such cases.

Trichotillomania is not diagnosed if the hair pulling or hair loss is attributable to another medical condition (e.g., inflammation of the skin or other dermatological conditions). Other causes of noncicatricial (nonscarring) alopecia (e.g., alopecia areata, androgenic alopecia, telogen effluvium) or cicatricial (scarring) (e.g., chronic discoid lupus erythematosus, lichen planopilaris, central centrifugal cicatricial alopecia, pseudopelade, folliculitis decalvans, dissecting folliculitis, acne keloidalis nuchae) should be considered in individuals with hair loss who deny hair pulling. Skin biopsy or dermoscopy can be used to differentiate individuals with trichotillomania from those with dermatological disorders. Hair-pulling symptoms may be exacerbated by certain substances—for example, stimulants—but it is less likely that substances are the primary cause of persistent hair pulling. Comorbidity Trichotillomania is often accompanied by other mental disorders, most commonly major depressive disorder and excoriation (skin-picking) disorder. Repetitive body-focused symptoms other than hair pulling or skin picking (e.g., nail biting) occur in the majority of individuals with trichotillomania and may deserve an additional diagnosis of other specified obsessivecompulsive and related disorder (i.e., other body-focused repetitive behavior disorder).

Excoriation (Skin-Picking) Disorder Diagnostic Criteria

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). Diagnostic Features The essential feature of excoriation (skin-picking) disorder is recurrent picking at one's own skin (Criterion A). The most commonly picked sites are the face, arms, and hands, but many individuals pick from multiple body sites. Individuals may pick at healthy skin, at minor skin irregularities, at lesions such as pimples or calluses, or at scabs from previous picking. Most individuals pick with their fingernails, although many use tweezers, pins, or other objects. In addition to skin picking, there may be skin rubbing, squeezing, lancing, and biting. Individuals with excoriation disorder often spend significant amounts of time on their picking behavior, sometimes several hours per day, and such skin picking may endure for months or years. Criterion A requires that skin picking lead to skin lesions, although individuals with this disorder often attempt to conceal or camouflage such lesions (e.g., with makeup or clothing). Individuals with excoriation disorder have made repeated attempts to decrease or stop skin picking (Criterion B). Criterion C indicates that skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. The term distress includes negative affects that may be experienced by individuals with skin picking, such as feeling a loss of control, embarrassment, and shame. Significant impairment may occur in several different areas of functioning (e.g., social, occupational, academic, and leisure), in

part because of avoidance of social situations. Associated Features Skin picking may be accompanied by a range of behaviors or rituals involving skin or scabs. Thus, individuals may search for a particular kind of scab to pull, and they may examine, play with, or mouth or swallow the skin after it has been pulled. Skin picking may also be preceded or accompanied by various emotional states. Skin picking may be triggered by feelings of anxiety or boredom, may be preceded by an increasing sense of tension (either immediately before picking the skin or when attempting to resist the urge to pick), and may lead to gratification, pleasure, or a sense of relief when the skin or scab has been picked. Some individuals report

Genetic and physiological. picking in response to a minor skin irregularity or to relieve an uncomfortable bodily sensation. Pain is not routinely reported to accompany skin picking. Some individuals engage in skin picking that is more focused (i.e., with preceding tension and subsequent relief), whereas others engage in more automatic picking (i.e., when skin picking occurs without preceding tension and without full awareness), and many have a mix of both behavioral styles. Skin picking does not usually occur in the presence of other individuals, except immediate family members. Some individuals report picking the skin of others. Prevalence An online survey of more than 10,000 adults, ages 18–69 years, age- and gender-matched to the U.S. population, found that 2.1% identified as having current excoriation disorder and 3.1% reported lifetime excoriation disorder. Three-quarters or more of individuals with the disorder are women in community samples. Development and Course Although individuals with excoriation disorder may present at various ages, the skin picking most often has onset during adolescence, commonly coinciding with or following the onset of puberty. The disorder frequently begins with a dermatological condition, such as acne. Sites of skin picking may vary over time. The usual course is chronic, with some waxing and waning if untreated. For some individuals, the disorder may come and go for weeks, months, or years at a time. Risk and Prognostic Factors There is evidence for a genetic vulnerability to excoriation disorder. The disorder is more common in individuals with obsessive-compulsive disorder (OCD) and their first-degree family members than in the general population. Culture-Related Diagnostic Issues There are limited data on the prevalence and clinical characteristics of excoriation disorder across cultures. However, clinical features appear similar in studies of individuals in the United States and other countries. Diagnostic Markers Most individuals with excoriation disorder admit to skin picking; therefore, dermatopathological diagnosis is rarely required. However, the disorder may have characteristic features on histopathology. Functional Consequences of Excoriation (Skin-Picking) Disorder Excoriation disorder is associated 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

Psychotic disorder. Other obsessive-compulsive and related disorders. Neurodevelopmental disorders. Dermatitis artefacta. Other disorders. Other medical conditions. 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 resulting from 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. **Differential Diagnosis** Skin picking may occur in response to a delusion (i.e., parasitosis) or tactile hallucination (i.e., formication) in a psychotic disorder. In such cases, excoriation disorder should not be diagnosed. Excessive washing compulsions in response to contamination obsessions in individuals with OCD may lead to skin lesions, and skin picking may occur in individuals with body dysmorphic disorder who pick their skin because of appearance concerns; in such cases, excoriation disorder should not be diagnosed. The description of other body-focused repetitive behavior disorder in other specified obsessive-compulsive and related disorder excludes individuals whose symptoms meet diagnostic criteria for excoriation disorder. While stereotypic movement disorder may be characterized by repetitive self-injurious behavior, onset is in the early developmental period. For example, individuals with the neurogenetic condition Prader-Willi syndrome may have early onset of skin picking, and their symptoms may meet criteria for stereotypic movement disorder. While tics in individuals with Tourette's disorder may lead to self-injury, the behavior is not tic-like in excoriation disorder. Dermatitis artefacta (also referred to as "factitious dermatitis") is a term used in dermatology to refer to medically unexplained, presumably self-induced skin lesions that the individual denies any role in creating. Cases in which there is evidence of deception on the individual's part concerning the skin lesions can be diagnosed as either malingering (if the skin picking is motivated by external incentives) or factitious disorder (if the skin picking occurs in the absence of obvious external rewards). In the absence of deception, excoriation disorder can be diagnosed if there are repeated attempts to decrease or stop skin picking. Excoriation disorder is not diagnosed if the skin picking is primarily attributable to the intention to harm oneself that is characteristic of nonsuicidal self-injury. Excoriation disorder is not diagnosed if the skin picking is primarily attributable to another medical condition. For example, scabies is a dermatological condition invariably associated with severe itching and scratching. However, excoriation disorder may be precipitated or exacerbated by an underlying dermatological condition. For example, acne may lead to some scratching and picking, which may also be associated with comorbid excoriation

Substance/medication-induced disorders. disorder (so-called acne excoriée). The differentiation between these two clinical situations (acne with some scratching and picking vs. acne with comorbid excoriation disorder) requires an assessment of the extent to which the individual's skin picking has become independent of the underlying dermatological condition. Skin-picking symptoms may also be induced by certain substances (e.g., cocaine), in which case excoriation disorder should not be diagnosed. If such skin picking is clinically significant, then a diagnosis of substance/medication-induced obsessive-compulsive and related disorder should be considered. **Comorbidity** Excoriation disorder is often accompanied by other mental disorders. Such disorders include OCD and trichotillomania (hair-pulling disorder), as well as major depressive disorder. Depression comorbidity seems to be more common in women. Repetitive body-focused symptoms other than skin picking and hair pulling (e.g., nail biting) occur in many individuals with excoriation disorder and may deserve an additional diagnosis of other specified obsessive-compulsive and related disorder (i.e., other body-focused repetitive behavior disorder). **Substance/Medication-Induced Obsessive-Compulsive and Related Disorder Diagnostic Criteria** A. Obsessions, compulsions, skin picking, hair pulling, other body-focused repetitive behaviors, or other symptoms characteristic of the obsessive-compulsive and related disorders predominate in the clinical picture. B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to or withdrawal from a medication.
2. The involved substance/medication is capable of producing the symptoms in Criterion A.
- C. The disturbance is not better explained by an obsessive-compulsive and related disorder that is not substance/medication-induced. Such evidence of an independent obsessive-compulsive and related disorder could include the following: The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after

the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent nonsubstance/medication-induced obsessive-compulsive and related disorder (e.g., a history of recurrent non-substance/medication-related episodes). D. The disturbance does not occur exclusively during the course of a delirium. E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Note: This diagnosis should be made in addition to a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and are sufficiently severe to warrant clinical attention. Coding note: The ICD-10-CM codes for the [specific substance/medication]-induced obsessive-compulsive and related disorders are indicated in the table below. Note that the ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. In any case, an additional separate diagnosis of a substance use disorder is not given. If a mild substance use disorder is comorbid with the substance-induced obsessive-compulsive and related disorder, the 4th position character is “1,” and the clinician should record “mild [substance] use disorder” before the substance-induced obsessive-compulsive and related disorder (e.g., “mild cocaine use disorder with cocaine-induced obsessive-compulsive and related disorder”). If a moderate or severe substance use disorder is comorbid with the substance-induced obsessive-compulsive and related disorder, the 4th position character is “2,” and the clinician should record “moderate [substance] use disorder” or “severe [substance] use disorder,” depending on the severity of the comorbid substance use disorder. If there is no comorbid substance use disorder (e.g., after a one-time heavy use of the substance), then the 4th position character is “9,” and the clinician should record only the substance-induced obsessive-compulsive and related disorder. ICD-10-CM With mild use disorder With moderate or severe use disorder Without use disorder Amphetamine-type substance (or other stimulant) F15.188 F15.288 F15.988 Cocaine F14.188 F14.288 F14.988 Other (or unknown) substance F19.188 F19.288 F19.988 Specify (see Table 1 in the chapter “Substance-Related and Addictive Disorders,” which indicates whether “with onset during intoxication” and/or “with onset during withdrawal” applies to a given substance class; or specify “with onset after medication use”): With onset during intoxication: If criteria are met for intoxication with the substance and the symptoms develop during intoxication.

289 With onset during withdrawal: If criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal. With onset after medication use: If symptoms developed at initiation of medication, with a change in use of medication, or during withdrawal of medication. Recording Procedures The name of the substance/medication-induced obsessive-compulsive and related disorder begins with the specific substance (e.g., cocaine) that is presumed to be causing the obsessive-compulsive and related symptoms. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class and presence

or absence of a comorbid substance use disorder. For substances that do not fit into any of the classes (e.g., ropinirole), the code for “other (or unknown) substance” should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the same code should also be used. To record the name of the disorder, the comorbid substance use disorder (if any) is listed first, followed by “with substance/medication-induced obsessive-compulsive and related disorder” (incorporating the name of the specific etiological substance/medication), followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal, with onset after medication use). For example, in the case of repetitive skin-picking occurring during intoxication in a man with a severe cocaine use disorder, the diagnosis is F14.288 severe cocaine use disorder with cocaine-induced obsessive-compulsive and related disorder, with onset during intoxication. A separate diagnosis of the comorbid severe cocaine use disorder is not given. If the substance-induced obsessive-compulsive and related disorder occurs without a comorbid substance use disorder (e.g., after a one-time heavy use of the substance), no accompanying substance use disorder is noted (e.g., F15.988 amphetamine-induced obsessive-compulsive and related disorder, with onset during intoxication). When more than one substance is judged to play a significant role in the development of the obsessive-compulsive and related disorder, each should be listed separately.

Diagnostic Features The essential features of substance/medication-induced obsessive-compulsive and related disorder are prominent symptoms of an obsessive-compulsive and related disorder (Criterion A) that are judged to be attributable to the effects of a substance (e.g., drug of abuse, medication). The obsessive-compulsive and related disorder symptoms must have developed during or soon after substance intoxication or withdrawal or after exposure to or withdrawal from a medication or toxin, and the substance/medication must be capable of producing the symptoms (Criterion B). Substance/medication-induced obsessive-compulsive and related disorder due to a prescribed treatment for a mental disorder or other medical condition must have its onset while the individual is receiving the medication. Once the treatment is discontinued, the obsessive-compulsive and related disorder symptoms will usually improve or remit within days to weeks.

Substance intoxication and substance withdrawal. Obsessive-compulsive and related disorder (i.e., not induced by a substance). (depending on the half-life of the substance/medication and the presence of withdrawal). The diagnosis of substance/medication-induced obsessive-compulsive and related disorder should not be given if onset of the obsessive-compulsive and related disorder symptoms precedes the substance/medication use, or if the symptoms persist for a substantial period of time, usually longer than 1 month, from the time of severe intoxication or withdrawal. The substance/medication-induced obsessive-compulsive and related disorder diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and are sufficiently severe to warrant independent clinical attention.

Associated Features Obsessions, compulsions, hair pulling, skin picking, or other body-focused repetitive behaviors can occur in association with intoxication with the following classes of substances: stimulants (including cocaine) and other (or unknown) substances. Heavy metals and toxins may also cause obsessive-compulsive and related disorder symptoms.

Prevalence In the U.S. general population, the very limited data that are available indicate that substance/medication-induced obsessive-compulsive and related disorder is very rare.

Differential Diagnosis Obsessive-compulsive and related disorder symptoms may occur in the context of substance intoxication and substance withdrawal. The diagnosis of the substance-specific intoxication or substance-specific withdrawal will usually suffice to categorize the symptom

presentation. A diagnosis of substance/medication-induced obsessive-compulsive and related disorder either with onset during intoxication or with onset during withdrawal should be made instead of a diagnosis of substance intoxication or substance withdrawal if the obsessive-compulsive and related disorder symptoms are judged to be in excess of those usually associated with intoxication or withdrawal and are sufficiently severe to warrant clinical attention.

Substance/medication-induced obsessive-compulsive and related disorder is distinguished from a primary obsessive-compulsive and related disorder by considering the onset, course, and other factors with respect to substances/medications. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings for use or intoxication.

Substance/medication-induced obsessive-compulsive and related disorder arises only in association with intoxication, whereas a primary obsessive-compulsive and related disorder may precede the onset of substance/medication use. The presence of features that are atypical of a primary obsessive-compulsive and related disorder, such as atypical age at onset of symptoms, may suggest a substance-induced etiology. A primary obsessive-compulsive and related disorder diagnosis is warranted if the symptoms persist for a substantial period of time (about 1 month or longer) after

Obsessive-compulsive and related disorder due to another medical condition. Delirium. F06.8 the end of the substance intoxication or the individual has a history of an obsessive-compulsive and related disorder. If the obsessive-compulsive and related symptoms are attributable to another medical condition (i.e., rather than to the medication taken for the other medical condition), obsessive-compulsive and related disorder due to another medical condition should be diagnosed. The history often provides the basis for judgment. At times, a change in the treatment for the other medical condition (e.g., medication substitution or discontinuation) may be needed to determine whether the medication is the causative agent (in which case the symptoms may be better explained by substance/medication-induced obsessive-compulsive and related disorder). If the disturbance is attributable to both another medical condition and substance use, both diagnoses (i.e., obsessive-compulsive and related disorder due to another medical condition and substance/medication-induced obsessive-compulsive and related disorder) may be given. When there is insufficient evidence to determine whether the symptoms are attributable to a substance/medication or to another medical condition or are primary (i.e., attributable to neither a substance/medication nor another medical condition), a diagnosis of other specified or unspecified obsessive-compulsive and related disorder would be indicated. If obsessive-compulsive and related disorder symptoms occur exclusively during the course of delirium, they are considered to be an associated feature of the delirium and are not diagnosed separately. Obsessive-Compulsive and Related Disorder Due to Another Medical Condition Diagnostic Criteria A. Obsessions, compulsions, preoccupations with appearance, hoarding, skin picking, hair pulling, other body-focused repetitive behaviors, or other symptoms characteristic of obsessive-compulsive and related disorder predominate in the clinical picture. B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition. C. The disturbance is not better explained by another mental disorder. D. The disturbance does not occur exclusively during the course of a delirium. E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if:

With obsessive-compulsive disorder-like symptoms: If obsessive-compulsive disorder-like symptoms predominate in the clinical presentation. With appearance preoccupations: If preoccupation with perceived appearance defects or flaws predominates in the clinical presentation. With hoarding symptoms: If hoarding predominates in the clinical presentation. With hair-pulling symptoms: If hair pulling predominates in the clinical presentation. With skin-picking symptoms: If skin picking predominates in the clinical presentation. Coding note: Include the name of the other medical condition in the name of the mental disorder (e.g., F06.8 obsessive-compulsive and related disorder due to cerebral infarction). The other medical condition should be coded and listed separately immediately before the obsessive-compulsive and related disorder due to the medical condition (e.g., I69.398 cerebral infarction; F06.8 obsessive-compulsive and related disorder due to cerebral infarction).

Diagnostic Features The essential feature of obsessive-compulsive and related disorder due to another medical condition is clinically significant obsessive-compulsive and related symptoms that are judged to be best explained as the direct pathophysiological consequence of another medical condition. Symptoms can include prominent obsessions, compulsions, preoccupations with appearance, hoarding, hair pulling, skin picking, or other body-focused repetitive behaviors (Criterion A). The judgment that the symptoms are best explained by the associated medical condition must be based on evidence from the history, physical examination, or laboratory findings (Criterion B). Additionally, it must be judged that the symptoms are not better explained by another mental disorder (Criterion C). The diagnosis is not made if the obsessive-compulsive and related symptoms occur only during the course of a delirium (Criterion D). The obsessive-compulsive and related symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion E). In determining whether the obsessive-compulsive and related symptoms are attributable to another medical condition, a medical condition must be present at the time of the onset of the obsessive-compulsive and related symptoms. Furthermore, it must be established that obsessive-compulsive and related symptoms can be etiologically related to the medical condition through a pathophysiological mechanism and that this best explains the symptoms in the individual. Although there are no infallible guidelines for determining whether the relationship between the obsessive-compulsive and related symptoms and the medical condition is etiological, considerations that may provide some guidance in making this diagnosis include the presence of a clear temporal association between the onset, exacerbation, or remission of the medical condition and the obsessive-compulsive and related symptoms; the presence of features that are atypical of a primary obsessive-compulsive and related disorder (e.g., atypical age at onset or

Delirium. course); and evidence in the literature that a known physiological mechanism (e.g., striatal damage due to a cerebral infarction) causes obsessive-compulsive and related symptoms. In addition, the disturbance cannot be better explained by a primary obsessive-compulsive and related disorder, a substance/medication-induced obsessive-compulsive and related disorder, or another mental disorder. There has been considerable attention to the question of whether obsessive-compulsive and related disorders can be attributed to Group A streptococcal infection. Sydenham's chorea is the neurological manifestation of rheumatic fever, which is in turn due to Group A streptococcal infection. Sydenham's chorea is characterized by a combination of motor and nonmotor symptoms. Nonmotor features include obsessions, compulsions, attention deficit, and emotional lability. Although individuals with Sydenham's chorea may present with non-neuropsychiatric features of acute rheumatic fever, such as carditis and arthritis, they may present with obsessive-compulsive disorder-like symptoms; such individuals should be diagnosed with

obsessive-compulsive and related disorder due to another medical condition. Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) has been identified as another postinfectious autoimmune disorder characterized by the sudden onset of obsessions, compulsions, and/or tics accompanied by a variety of acute neuropsychiatric symptoms in the absence of chorea, carditis, or arthritis, after Group A streptococcal infection. However, given that such acute-onset symptoms may be due to a range of other infections or insults, the term pediatric acute-onset neuropsychiatric syndrome (PANS) has been used. PANS is characterized by abrupt, dramatic onset of obsessive-compulsive symptoms or severely restricted food intake, together with a range of additional neuropsychiatric symptoms. Assessment guidelines for this syndrome are available. Associated Features A number of other medical conditions are known to include obsessive-compulsive and related symptoms as a manifestation. Examples include disorders leading to striatal damage, such as cerebral infarction or Huntington's disorder. Development and Course The development and course of obsessive-compulsive and related disorder due to another medical condition generally follows the course of the underlying illness. Diagnostic Markers Laboratory assessments and/or medical examinations are necessary to confirm the diagnosis of another medical condition. Differential Diagnosis A separate diagnosis of obsessive-compulsive and related disorder due to another medical condition is not given if the disturbance occurs exclusively during the course of a delirium. However, a diagnosis of obsessive-compulsive and related disorder due to

Mixed presentation of symptoms (e.g., mood and obsessive-compulsive and related symptoms) judged to be due to another medical condition. Substance/medication-induced obsessive-compulsive and related disorders. Obsessive-compulsive and related disorders (primary). Illness anxiety disorder. Associated feature of another mental disorder. Other specified obsessive-compulsive and related disorder or unspecified obsessive-compulsive and related disorder. another medical condition may be given in addition to a diagnosis of major neurocognitive disorder (dementia) if the etiology of the obsessive-compulsive symptoms is judged to be a physiological consequence of the pathological process causing the dementia and if obsessive-compulsive symptoms are a prominent part of the clinical presentation. If the presentation includes a mix of different types of symptoms, the specific mental disorder due to another medical condition depends on which symptoms predominate in the clinical picture. If there is evidence of recent or prolonged substance use (including medications with psychoactive effects), withdrawal from a substance, or exposure to a toxin, a substance/medication-induced obsessive-compulsive and related disorder should be considered. When a substance/medication-induced obsessive-compulsive and related disorder is being diagnosed in relation to drugs of abuse, it may be useful to obtain a urine or blood drug screen or other appropriate laboratory evaluation. Symptoms that occur during or shortly after (i.e., within 4 weeks of) substance intoxication or withdrawal or after medication use may be especially indicative of a substance/medication-induced obsessive-compulsive and related disorder, depending on the type, duration, or amount of the substance used. Obsessive-compulsive and related disorder due to another medical condition should be distinguished from a primary obsessive-compulsive and related disorder. In primary mental disorders, no specific and direct causative physiological mechanisms associated with a medical condition can be demonstrated. Acute-onset symptoms, late age at onset, or atypical symptoms suggest the need for a thorough assessment to rule out the diagnosis of obsessive-compulsive and related disorder due to another medical condition. Illness anxiety disorder is characterized by a preoccupation with having or acquiring a serious illness. In the case of illness anxiety disorder, individuals may or may

not have diagnosed medical conditions. Obsessive-compulsive and related symptoms may be an associated feature of another mental disorder (e.g., schizophrenia, anorexia nervosa). These diagnoses are given if it is unclear whether the obsessive-compulsive and related symptoms are primary, substance-induced, or due to another medical condition. Other Specified Obsessive-Compulsive and Related Disorder F42.8 This category applies to presentations in which symptoms characteristic of an obsessive-compulsive and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

predominate but do not meet the full criteria for any of the disorders in the obsessive-compulsive and related disorders diagnostic class. The other specified obsessive-compulsive and related disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific obsessive-compulsive and related disorder. This is done by recording “other specified obsessive-compulsive and related disorder” followed by the specific reason (e.g., “obsessional jealousy”). Examples of presentations that can be specified using the “other specified” designation include the following:

1. Body dysmorphic-like disorder with actual flaws: This is similar to body dysmorphic disorder except that the defects or flaws in physical appearance are clearly observable by others (i.e., they are more noticeable than “slight”). In such cases, the preoccupation with these flaws is clearly excessive and causes significant impairment or distress.
2. Body dysmorphic-like disorder without repetitive behaviors: Presentations that meet body dysmorphic disorder except that the individual has never performed repetitive behaviors or mental acts in response to the appearance concerns.
3. Other body-focused repetitive behavior disorder: Presentations involving recurrent body-focused repetitive behaviors other than hair pulling and skin picking (e.g., nail biting, lip biting, cheek chewing) that are accompanied by repeated attempts to decrease or stop the behaviors and that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
4. Obsessional jealousy: This is characterized by nondelusional preoccupation with a partner’s perceived infidelity. The preoccupations may lead to repetitive behaviors or mental acts in response to the infidelity concerns; they cause clinically significant distress or impairment in social, occupational, or other important areas of functioning; and they are not better explained by another mental disorder such as delusional disorder, jealous type, or paranoid personality disorder.
5. Olfactory reference disorder (olfactory reference syndrome): This is characterized by the individual’s persistent preoccupation with the belief that he or she emits a foul or offensive body odor that is unnoticeable or only slightly noticeable to others; in response to this preoccupation, these individuals often engage in repetitive and excessive behaviors such as repeatedly checking for body odor, excessive showering, or seeking reassurance, as well as excessive attempts to camouflage the perceived odor. These symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. In traditional Japanese psychiatry, this disorder is known as jikoshu-kyofu, a variant of taijin kyofusho (see “Culture and Psychiatric Diagnosis” in Section III).
6. Shubo-kyofu: A variant of taijin kyofusho (see “Culture and Psychiatric Diagnosis” in Section III) that is similar to body dysmorphic disorder and is characterized by excessive fear of having a bodily deformity.

7. Koro: Related to dhat syndrome (see “Culture and Psychiatric Diagnosis” in Section III), an episode of sudden and intense anxiety that the penis in males (or the vulva and nipples in females) will recede into the body, possibly leading to death. Unspecified Obsessive-Compulsive and Related Disorder F42.9 This category applies to presentations in which symptoms characteristic of an obsessive-compulsive and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the obsessive-compulsive and related disorders diagnostic class. The unspecified obsessive-compulsive and related disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific obsessive-compulsive and related disorder and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).
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