# Obsessions

1. Recurrent and persistent thoughts, impulses, 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 thoughts, impulses or images are not simply excessive worries about real-life problems

3. The person attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action

4. The person recognizes that the obsessional thoughts, urges, or images are a product of his or her own mind (not imposed from without as in thought insertion)

# Compulsions

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts either 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.

# Obsessive-Compulsive Disorder (1/3)

A. Presence of either obsessions, compulsions, or both.

B. The obsessions or compulsions are time consuming (take more than 1 hour/day), or cause significant distress, or impairment in social, occupational (or academic), 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.

# Obsessive-Compulsive Disorder (2/3)

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, skin picking as in Excoriation Disorder; stereotypies, as in Stereotypic Movement Disorders; 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 [Hypochondriasis]; 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).

# Obsessive-Compulsive Disorder (3/3)

Specifier:

With Good or Fair Insight – The individual recognizes that the 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 that the Obsessive-Compulsive Disorder beliefs are probably true.

With Absent Insight/Delusional Beliefs – The individual is completely convinced that Obsessive-Compulsive Disorder beliefs are true.

Tic-related – The individual has a current or past history of a tic disorder.

# Hoarding Disorder (1/3)

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 significant distress, or impairment in social, occupational (or academic), 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).

# Hoarding Disorder (2/3)

D. 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).

Specifier:

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.

# Hoarding Disorder (3/3)

More Specifiers:

With Good or Fair Insight – The individual recognizes that the hoarding-related beliefs and behaviors (pertaining to the difficulty discarding items, clutter, or excessive acquisition) are problematic.

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

# Hoarding Disorder

Community surveys estimate current prevalence as 2-6%.

DSM5 – appears to begin early in life and generally has a chronic course into late stages of life

# Trichotillomania

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).

12-month Prevalence is 1-2%.

Males and females equal in children, more common in females in adults (10F:1M)

# Excoriation Disorder

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 the 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, steroetypies in Stereotypic Movement Disorder, or intention to harm oneself in nonsuicidal self-injury).

12-month Prevalence is 1.4%., 3F:1M

# Body Dysmorphic Disorder (1/2)

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 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.

# Body Dysmorphic Disorder (2/2)

Specifiers:

With Good or Fair Insight – The individual recognizes that the Body Dyspmorphic 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 Dyspmorphic Disorder beliefs are probably true.

With Absent Insight/Delusional Beliefs – The individual is completely convinced that Body Dyspmorphic Disorder beliefs are true.

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.

# Body Dysmorphic Disorder

Current prevalence is estimated to be 2.2-2.5% in the adult population

- 9-15% of U.S. individuals seeking dermatological treatment
- 7-8% of U.S. individuals seeking cosmetic surgery
  (3-16% internationally)
- 8% of U.S. orthodontia patients
- 10% of US oral/maxillofacial surgery patients

DSM5 – Mean age of onset is 16-17 years, most common age is 12-13 years.

Katherine Phillips' study of 200 individuals diagnosed with BDD:

- Mean age: 32 (with majority between 24-45 years of age)
- Marital Status: 64% single, 25% married, 12% divorced
- Onset: sudden (20%), gradual (80%)
  - chronicity reported by 84%
  - 59% reported worsening of symptoms over time, 13% reported improvement, 28% reported stable

# Body Dysmorphic Disorder

Preoccupations with defect can reach delusional proportions where individuals persist in obtaining plastic surgeries to “correct” for the defect (except that it keeps on going)

High cormorbidity with OCD (25%), Social Phobia (32%), and Major Depressive Disorder (58%)

# Body Dysmorphic Disorder - Etiology

Sociocultural:

- Media influences through “representation” of “perfection”

- Makeover Reality shows (improvement suggests problematic original and assigns value to “improvement”)

- Cosmetic procedures (both surgical and nonsurgical) increased by 44% in 2004 to a total of 11.9 million (approximately 40,000 procedures/day)

- Some cultures “reward” physical symptoms with attention and caring and “punish” emotional symptoms through devaluation or dismissing

# Obsessive-Compulsive D/os - Treatment

Pharmacological:

High dosages of SSRIs

- decreases obsessiveness, allowing individuals to focus on other things
- subsequent reduction in self-consciousness, depression
- subsequent increase in engagement in pleasurable activities that in turn, take up an individual's attention

# Obsessive-Compulsive D/os - Treatment

Cognitive-Behavioral:

Exposure to feared stimuli (imaginal or in vivo) and response prevention

Restructure cognitions related to bodily sensations as well as addressing automatic thoughts about vulnerability and helplessness

# Obsessive-Compulsive D/os - Treatment

Family Systems:

Modeling may be helpful (can also raise interfering dynamics that will need to be processed)

No enabling is critical