

The background of the slide is a soft-focus photograph of a natural landscape. It features a calm body of water in the foreground, which perfectly reflects the scene above. In the middle ground, there is a dense line of green trees along the shore. The background is composed of rolling mountains or hills, their peaks shrouded in a thick, white mist or fog. The overall color palette is muted and soothing, with various shades of teal, light blue, and pale green. The lighting is diffused, creating a tranquil and somewhat ethereal atmosphere.

OCD and related Disorders

Obsessive Compulsive Disorder

- **Criteria A:** Presence of obsessions, compulsions, or both:
- **Obsessions** are defined by:
 - 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. Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
 - 2. The behaviours or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviours or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive

Criteria continued...

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

- Obsessive-compulsive and related disorders that have a cognitive component have insight as the basis for specifiers; in each of these disorders, insight ranges from "good or fair insight" to "poor insight" to "absent insight/delusional beliefs" with respect to disorder related beliefs.
- 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.

Specifiers:

- Many individuals with OCD have dysfunctional beliefs -
- inflated sense of responsibility and the tendency to overestimate threat;
- perfectionism and intolerance of uncertainty;
- over-importance of thoughts (e.g., believing that having a forbidden thought is as bad as acting on it) and the need to control thoughts.
- Individuals with 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. Some have poor insight and a few (4% or less) have absent insight/delusional beliefs.
- 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 males 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.

Prevalence and onset

- The 12-month prevalence of OCD in the United States is 1.2%, with a similar prevalence internationally (1.1%-1.8%).
- Females are affected at a slightly higher rate than males in adulthood, although males are more commonly affected in childhood.
- 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.
- Males have an earlier age at onset than females: nearly 25% of males have onset before age 10 years.
- The onset of symptoms is typically gradual; however, acute onset has also been reported.
- Onset 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 co-occurrence of other disorders.

Risk factors and aetiology

- **Temperament** Greater internalizing symptoms, higher negative emotionality, and behavioural inhibition in childhood are possible temperamental risk factors.
- **Environmental:** Physical and sexual abuse in childhood and other stressful or traumatic events have been associated with an increased risk for developing OCD.
- 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 post-infectious autoimmune syndrome.
- **Genetic and physiological:** 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).
- Dysfunction in the orbitofrontal cortex, anterior cingulate cortex, and striatum have been most strongly implicated.

Neuroanatomy/neurobiology

Images of the brain have revealed some differences between people with OCD and those without it, but these differences are small and not consistently observed.

It is challenging to interpret what these findings mean. This is partly due to a "chicken and egg" issue: many brain imaging studies don't clarify whether these differences *cause OCD* or *are caused by OCD*.

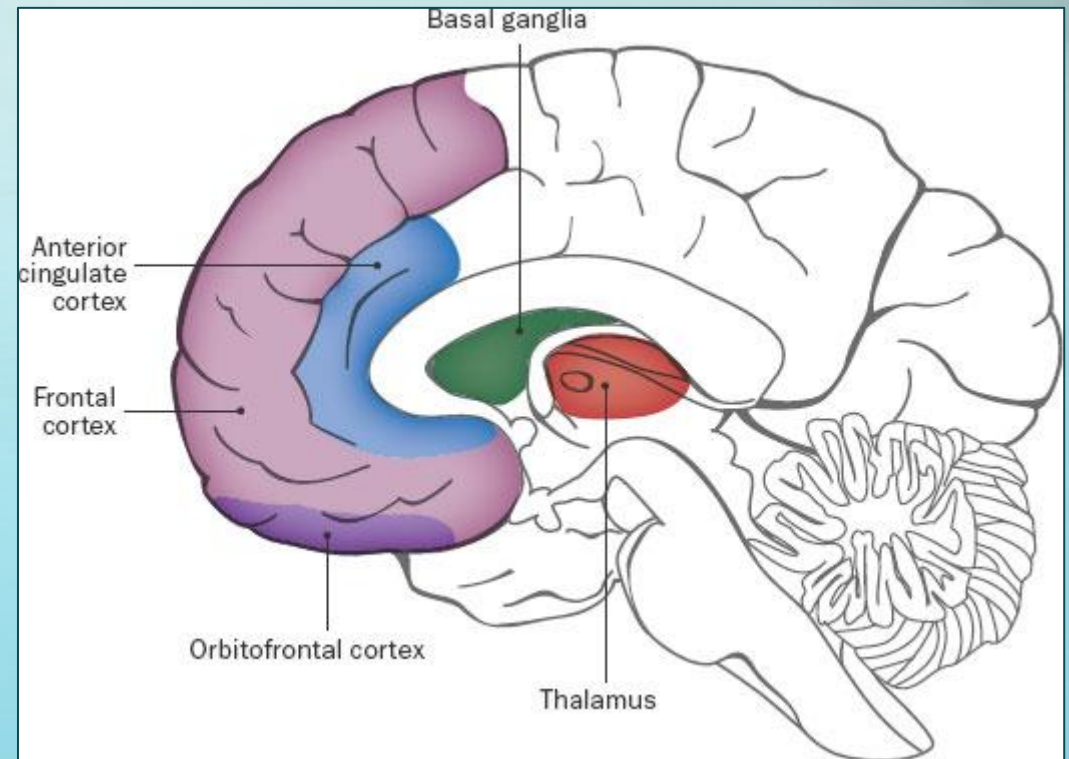
Parts of the brain affected by OCD include the orbitofrontal cortex (OFC), the anterior cingulate cortex (ACC), the thalamus, and the basal ganglia.

The **OFC** is involved in shaping our thoughts, memories, emotions, and intuitive/gut feelings - also known as "visceral states."

The **ACC** helps us detect or predict errors, and plays a role in attention, motivation, memory, and emotion.

The **thalamus** sends signals to the brain that relate to physical movement and sensation.

The **basal ganglia** helps us plan and carry out our actions and behaviours. Overactivity in these parts of the brain has been found in people with OCD.



Neurotransmitters

- While medications like serotonin reuptake inhibitors can help reduce OCD symptoms, there is no conclusive research evidence that OCD is caused solely by a dysfunction serotonin levels, or of other neurotransmitters.
- The idea that "chemical imbalances" are the only cause of OCD is outdated and too simplistic.
- However, an imbalance in neurotransmitters can *play a role in OCD*, with strong evidence that serotonin is implicated Derksen, et al. (2020). Research has also shown that differences in dopamine, glutamate, and GABA can also contribute to the progression of OCD.
- However, the environment plays some role, since the types of obsessions and compulsions that people have differ for members of different cultural, ethnic, sexual, and religious groups.
- Moreover, the themes of obsessional fears tend to change over time: in the 1980s, for example, there was an increase in obsessions related to HIV/AIDS, which coincided with the spread of this disease. A similar phenomenon has taken place during the recent COVID-19 pandemic Dennis et al. (2023).

What About PANDAS/PANS?

- PANDAS (Paediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infections) and PANS (Paediatric Acute-onset Neuropsychiatric Syndrome) are disorders related to OCD that occur in childhood following the body's reaction to an infection.
- PANDAS is associated with Group A Streptococcus - the bacteria responsible for strep throat and other serious infections (Thienemann et al., 2017)
- PANDAS and PANS look very different from other forms of childhood OCD, with the obvious difference being that they happen suddenly; the child develops symptoms overnight that have a very severe impact on their life.

Treatment for OCD

- The most effective treatments for OCD are **Cognitive Behaviour Therapy (CBT)** and/or medication
- More specifically, the most effective treatments are a type of CBT called Exposure and Response Prevention (ERP), which has the strongest evidence supporting its use in the treatment of OCD, and/or a class of serotonin reuptake inhibitors, or SRIs.
- Taken together, ERP and medication are considered the “first-line” treatments for OCD.
- About 70% of people will benefit from ERP and/or medication for their OCD.
- Anafranil (clomipramine) is the best-studied OCD medication. There is growing evidence that the other drugs are as effective. For example, duloxetine has been reported to help OCD patients who have not responded to these other medications.

Exposure Response Prevention

- The **exposure** component of ERP refers to practicing confronting the thoughts, images, objects, and situations that cause the anxious obsessions.
- The **response prevention** part of ERP refers to making a choice not to do a compulsive behaviour once the anxiety or obsessions have been “triggered.”
- All of this is conducted under the guidance of a therapist at the beginning — until the client will learn to do their own ERP exercises to help manage their symptoms. Over time, the treatment will “retrain the brain” to no longer see the object of the obsession as a threat.

The other disorders

- 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 behaviours 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 behaviours or mental acts in response to the preoccupations.
- Other obsessive-compulsive and related disorders are characterized primarily by **recurrent body-focused repetitive behaviours** (e.g., hair pulling, skin picking) and repeated attempts to decrease or stop the behaviours.

Body Dysmorphic 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 slightly to others, and by repetitive behaviours (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.



Diagnostic criteria

- Criteria A: Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.
- Criteria B: At some point during the course of the disorder, the individual has performed repetitive behaviours (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.
- Criteria C: The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Criteria 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.

- 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."
- Excessive repetitive behaviours or mental acts (e.g., comparing) are performed in response to the preoccupation (Criterion B). The individual feels driven to perform these behaviours, which are not pleasurable and may increase anxiety and dysphoria.
- 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.

Prevalence and onset

- The point prevalence among U.S. adults is 2.4%. Outside the United States current prevalence is approximately 1.7%-1.8%, with a gender distribution similar to that in the United States.
- The current prevalence is 9%-15% among dermatology patients, 7%-8% among U.S. cosmetic surgery patients, 3%-16% among international cosmetic surgery patients (most studies), 8% among adult orthodontia patients, and 10% among patients presenting for oral or maxillofacial surgery.
- The mean age at disorder onset is 16-17 years with the most common age at onset 12-13 years. Two-thirds of individuals have the disorder onset before age 18.
- The 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 are more likely to attempt suicide, have more comorbidity, and gradual disorder onset than those with adult-onset body dysmorphic disorder.

Risk and aetiology

- **Environmental:**

- Body dysmorphic disorder has been associated with high rates of childhood neglect and abuse.

- **Culture:**

- Body dysmorphic disorder has been reported internationally. It appears that the disorder may have more similarities than differences across races and cultures but that cultural values and preferences may influence symptom content to some degree.
- Societal pressures and media portrayals of unrealistic beauty standards can contribute to the development and maintenance of BDD.

Aetiologies

- Genetic and physiological:
- There's a higher likelihood of developing BDD if a first-degree relative (parent, sibling, or child) has it, suggesting a genetic component.
- The prevalence of body dysmorphic disorder is elevated in first-degree relatives of individuals with obsessive-compulsive disorder (OCD).
- Brain differences
- Research suggests that people with BDD may have differences in brain structure, chemistry, and activity, particularly in areas related to visual and emotional processing.

Environmental/societal:

- **Low self-esteem and perfectionism:** Individuals with BDD often have low self-esteem and may hold unrealistic standards of perfection, leading to intense focus on perceived flaws.
- **Negative body image:** A distorted or negative perception of one's appearance can contribute to the development of BDD.
- **Social Anxiety:** Social anxiety, particularly regarding appearance, can precede or co-occur with BDD.
- **Environmental Factors:**
- **Childhood Trauma:** A history of childhood abuse, neglect, or bullying may increase the risk of developing BDD.

Treatment of BDD

- As always, **Psychotherapy** is advocated: This is the technical term for mental health therapy, and there are multiple forms of psychotherapy that might help. Psychotherapy focuses on talking about feelings or experiences, and helping an individual develop beneficial thought processes and coping strategies. Two of the most common types used in treating BDD are **CBT** and **Family Therapy**.
- **Medications:** **Antidepressants** are a common part of treatment for BDD. These medications can help with symptoms of BDD, making it easier to manage thoughts and behaviours. These medications can also make other forms of treatment like psychotherapy more effective.

Prognosis

- BDD's effects tend to be mild at first and worsen over time. The negative thoughts and feelings about your body will influence thought processes and behaviours. As they become more intense, individuals will become more distressed about appearance. They may also start to affect or change life perceptions, making it difficult to study, work or spend time with others socially.
- BDD usually becomes more severe the longer it goes untreated. That's why it's important to get a diagnosis and treatment as soon as possible. Early diagnosis and treatment may stop BDD's symptoms and effects from worsening.
- **How long does body dysmorphic disorder last?**
- BDD is treatable and it's often possible to manage it. Unfortunately, it isn't curable and doesn't go away on its own. Once it develops, it's a lifelong condition.
- Receiving treatment for BDD can allow remission, meaning symptoms fade, weaken or even go away. While it's possible to have a relapse where symptoms return, flare up or become more severe, effective treatment can help manage BDD, limiting its effects on life.
- **What's the outlook for this condition?**
- BDD is a treatable condition. Research estimates that between 50% and 80% of people treated with medication experience fewer or less severe symptoms and are less likely to experience relapses where symptoms return or become more severe again.
- Experts strongly recommend combining medication treatments with psychotherapy. That's because psychotherapy can help develop thinking and coping strategies that counter the thoughts and feelings experienced with BDD.
- Without treatment, body dysmorphic disorder has the potential to disrupt life severely. Self-harm or suicide are also more common among people living with untreated BDD. Up to 80% of people with BDD have suicidal thoughts, and 1 in 4 people with BDD attempt suicide. People with BDD are also 45 times more likely to die by suicide than people without it. Because of this, early diagnosis and treatment — especially in people who develop BDD before age 18 — are critical.

Hoarding Disorder

- 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 to 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.

Diagnostic criteria:

- Criteria A: Persistent difficulty discarding or parting with possessions, regardless of their actual value.
- Criteria B: This difficulty is due to a perceived need to save the items and to distress associated with discarding them.
- Criteria C: The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use.
- Criteria 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).
- Criteria E: The hoarding is not attributable to another medical condition.
- Criteria F: The hoarding is not better explained by the symptoms of another mental disorder.

- 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. Stealing is less common.
- The essential feature of hoarding disorder is persistent difficulties discarding or parting with possessions, regardless of their actual value (Criterion A).
- Individuals with hoarding disorder purposefully save possessions and experience distress when facing the prospect of discarding them (Criterion B).
- 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).
- Symptoms (i.e., difficulties 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).

Prevalence and onset

- Community surveys estimate the point of clinically significant hoarding in the United States and Europe to be approximately 2%-6%.
- Hoarding disorder affects both males and females, but some studies have reported a significantly greater prevalence among males.
- This contrasts with clinical samples, which are predominantly female.
- Hoarding symptoms appear to be almost three times more prevalent in older adults (ages 55-94 years) compared with younger adults (ages 34-44 years).
- Hoarding appears to begin early in life and spans well into the late stages. Hoarding symptoms may first emerge around ages 11-15 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. Once symptoms begin, the course of hoarding is often chronic.

Risk and aetiology

- **Temperamental:**
- Indecisiveness is a prominent feature of individuals with hoarding disorder and their first-degree relatives.
- **Environmental:**
- **Traumatic Events:**
- Experiencing traumatic events, such as loss, abuse, or significant life stressors, can trigger or worsen hoarding behaviours.
- Individuals with hoarding disorder often retrospectively report stressful and traumatic life events preceding the onset of the disorder or causing an exacerbation.
- **Genetic and physiological:**
- Hoarding behaviour is familial, with about 50% of individuals who hoard reporting having a relative who also hoards. Twin studies indicate that approximately 50% of the variability in hoarding behaviour is attributable to additive genetic factors.

Aetiologies continued...

- **Emotional Attachment to Possessions:**
 - Some individuals may develop strong emotional attachments to their possessions, making it difficult to discard them, even if they are no longer needed or useful.
- **Social Isolation and Loneliness:**
 - Hoarding can sometimes be a way of coping with feelings of isolation or loneliness, with clutter serving as a sense of comfort or security.
- **Family History and Habits:**
 - Growing up in a cluttered or chaotic environment can contribute to the development of hoarding behaviours.
- **Cognitive Deficits:**
 - Information processing deficits, including difficulty with planning, problem-solving, and organization, can make it harder for individuals to manage their possessions and maintain a clutter-free environment.

Treatment

- 1. Cognitive Behavioural Therapy (CBT):
 - **Focus:** CBT helps individuals understand and challenge the thoughts and beliefs that lead to hoarding behaviours, such as the fear of discarding items or the belief that they might be needed in the future.
 - **Skills Training:** CBT teaches skills to resist the urge to acquire more possessions, improve decision-making and organization, and learn to cope with the anxiety associated with discarding items.
 - **In-Home Visits:** Therapists may conduct in-home visits to help individuals declutter and practice new skills in their own environment.
 - **Group or Family Therapy:** CBT can be provided in individual, group, or family settings.
 - **Motivational Interviewing:** Techniques to increase motivation for change and engagement in treatment.

Other options

- **Antidepressants:**

- Selective serotonin reuptake inhibitors (SSRIs) are sometimes used to address co-occurring anxiety or depression, which can exacerbate hoarding behaviours. In some cases, other medications may be considered, but more research is needed.

- **Early Intervention:**

- Seeking help early on can improve outcomes.

- **Family Support:**

- Family members can play a crucial role in supporting the individual with hoarding disorder by encouraging treatment and creating a safe and supportive environment.

- **Professional Organizers:**

- In some cases, professional organizers can assist with decluttering and organizing the home, but it's important to work with a therapist to address the underlying issues.

- **Virtual Reality:**

- Scientists are exploring virtual reality technology to help individuals with hoarding disorder experience the sensation and benefits of decluttering.

Trichotillomania (hair-pulling disorder)

- 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 (skin-picking) 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 behaviours 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 behaviour while engaging in it, with some individuals displaying more focused attention on the behaviour (with preceding tension and subsequent relief) and other individuals displaying more automatic behaviour (with the behaviours seeming to occur without full awareness).

Diagnostic criteria

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

Prevalence and onset

- In the general population, the 12-month prevalence estimate for trichotillomania in adults and adolescents is 1%-2%. Females are more frequently affected than males, at a ratio of approximately 10:1.
- This estimate likely reflects the true gender ratio of the condition, although it may also reflect differential treatment seeking based on gender or cultural attitudes regarding appearance (e.g., acceptance of normative hair loss among males).
- Among children with trichotillomania, males and females are more equally represented.
- Hair pulling may be seen in infants, and this behaviour 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.

Aetiologies: Trichotillomania

- **Genetic Predisposition:**

- There's evidence suggesting that trichotillomania can run in families, indicating a genetic component.

- **Brain Chemistry:**

- Some research suggests that imbalances in brain chemicals, similar to those seen in obsessive-compulsive disorder (OCD), may play a role.

- **Brain Structure:**

- Studies have shown structural differences in the brains of individuals with trichotillomania, including changes in the grey and white matter tracts

- **Hormonal Fluctuations:**

- Changes in hormone levels, particularly during puberty, may trigger or exacerbate hair-pulling behaviours.

Aetiologies continued...from a psychological perspective

- **Coping Mechanism/stress:**

- Many people with trichotillomania report that hair-pulling helps them to cope with stress, anxiety, or boredom.

- **Habit Formation/boredom:**

- The act of pulling hair can become a rewarding habit, as it provides a brief sense of relief, leading to a cycle of pulling.

- **Self-Soothing/social isolation:**

- Some individuals use hair-pulling as a way to self-soothe or reduce emotional distress.

- **Obsessive-Compulsive Spectrum:**

- Trichotillomania is often considered to be part of the obsessive-compulsive spectrum, alongside conditions like OCD and body dysmorphic disorder.

Treatments

- **Habit Reversal Training (HRT):**
- This is a behavioural therapy that helps individuals identify triggers for hair-pulling and learn alternative behaviours to replace the urge to pull.
- **Cognitive Behavioural Therapy (CBT):**
- CBT can help individuals understand the thoughts and feelings that contribute to hair-pulling and develop coping mechanisms.
- **Acceptance and Commitment Therapy (ACT):**
ACT helps individuals accept urges to pull hair without acting on them, focusing on values and goals.
- **Social Support:**
- Family and loved ones can learn how to provide support and encouragement, recognizing triggers or behavioral patterns, and intervening when needed.

Medication and other options

- **Antidepressants:**
- Some individuals may benefit from medication, such as selective serotonin reuptake inhibitors (SSRIs) or tricyclic antidepressants, to address underlying anxiety or depression that may contribute to hair-pulling.
- **Keeping hands busy:**
- Squeezing a stress ball, using a fidget toy, or wearing gloves can help redirect attention and reduce the urge to pull.
- **Short hair and awareness of triggers**
- **Support and coping mechanisms**

Excoriation (Skin-Picking) Disorder

- Diagnostic criteria
- Criteria A: Recurrent skin picking resulting in skin lesions.
- Criteria B: Repeated attempts to decrease or stop skin picking.
- Criteria C: The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Criteria D: The skin picking is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., scabies).
- Criteria E: The skin picking is not better explained by symptoms of another mental disorder.

Prevalence and onset

- In the general population, the lifetime prevalence for excoriation disorder in adults is 1.4% or somewhat higher. Three-quarters or more of individuals with the disorder are female.
- 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.

Treatment

- **Habit Reversal Training (HRT):** This is a specific type of CBT that focuses on helping individuals become more aware of their skin-picking triggers and behaviours, and then develop alternative, less harmful responses.
- **Awareness Training:** Learn to recognize when and why you're picking.
- **Stimulus Control:** Identify and avoid situations that trigger the behavior.
- **Competing Response Training:** Replace skin picking with a different activity, like clenching your fist or knitting.
- **Other CBT approaches:** Acceptance and Commitment Therapy (ACT) may also be helpful.

Other treatments/strategies

- **Selective Serotonin Reuptake Inhibitors (SSRIs):**
- These antidepressants can be helpful in reducing skin picking, particularly if it's related to anxiety or depression.
- **Other Medications:**
- Some research suggests that N-acetylcysteine (NAC) or lamotrigine (an anti-seizure medication) may also be helpful.
- **Keep hands busy:** Use fidget toys, stress balls, or other items to keep your hands occupied. Use moisturizer.
- **Seek support and establish routines.**

Treatments: general observations

- Exposure and Response Prevention (Foa & Kozak, 1986).
 - Exposure versus response prevention versus EX/RP.
 - Gradual versus abrupt exposures.
 - Use of imaginal exposure.
 - Session frequency.
- Cognitive Therapies.
- Serotonergic Medications.
- Combined efficacy of EX/RP and pharmacotherapy.
- Pharmacotherapy and CBT strategies for SRI partial responders.
- Alternative strategies to discourage the repetitive behaviours.