# Treatment of Obsessive-Compulsive Related Disorders

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# Disclosures

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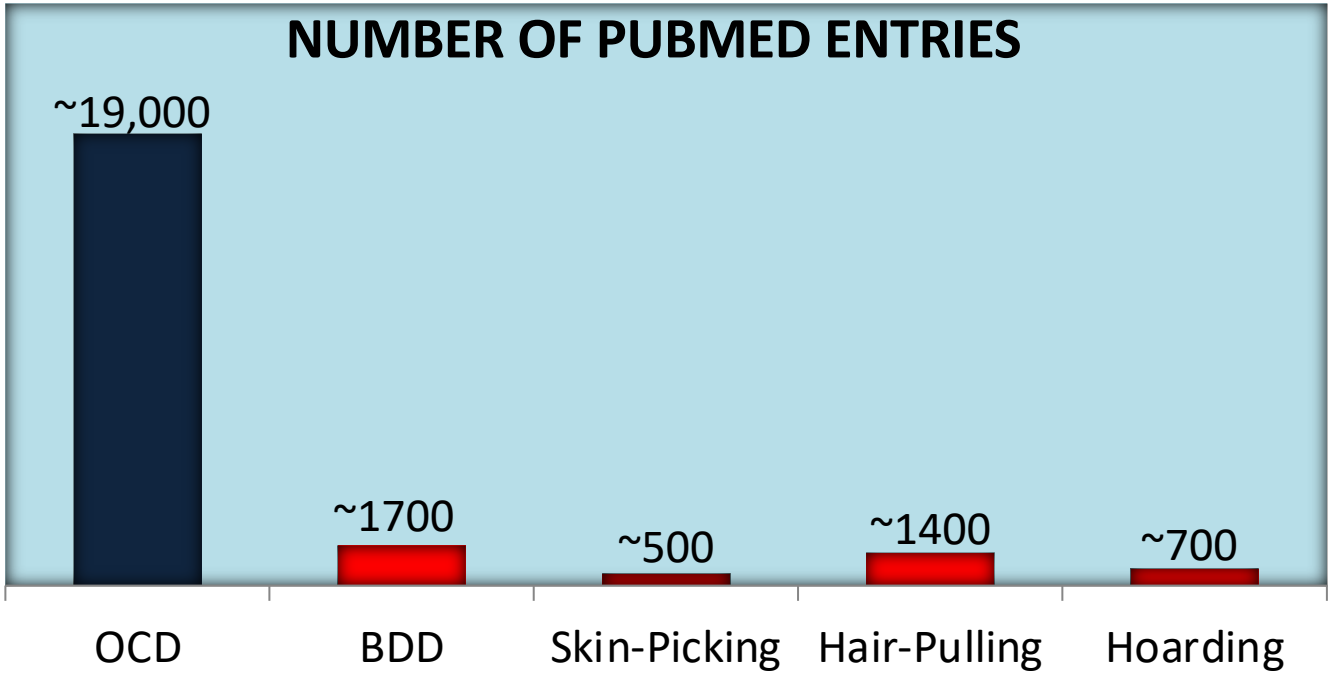
# Obsessive-Compulsive Related Disorders (OCRDs)

- Body Dysmorphic Disorder
- Excoriation (Skin-Picking) Disorder
- Trichotillomania (Hair-Pulling Disorder)
- Hoarding Disorder

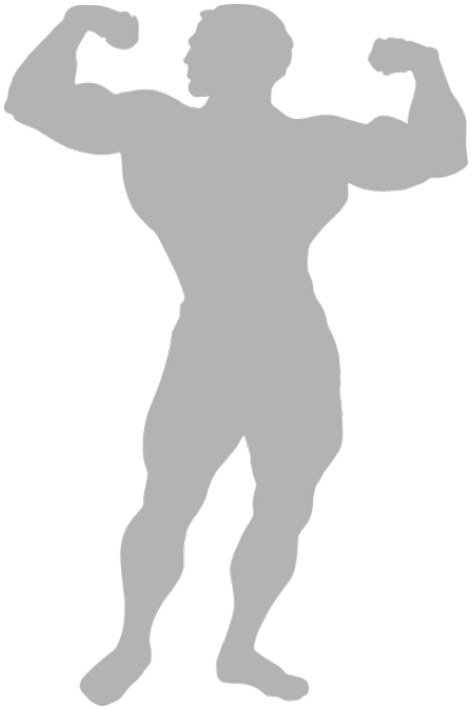
Off-label



# Body Dysmorphic Disorder (BDD)

# Clinical features of BDD

- Distressing preoccupation with **imagined or slight defect in appearance**
- Usually involves skin, hair, nose, but can involve any body part
- Variable insight, may be **delusional**
- Pts often present to a dermatologist or cosmetic surgeon



- **Common:** 2.4 % prevalence in general population, 12 % in outpatient dermatology clinic, and 33% in pts seeking rhinoplasty



Phillips. *Understanding body dysmorphic disorder : an essential guide*. 2009; Bjornsson. *Dialogues Clin Neurosci. 2010*; Pope. *Body Image.* 2005; Phillips. *J Psychiatr Res.* 2006; Mancuso. *Compr Psychiatry*. 2010

# Clinical features of BDD (cont.)

- **Repetitive behaviors**
  - Mirror checking
  - Excessive grooming
  - Camouflaging
  - Comparing
  - Reassurance seeking
- Avoidance, may be housebound
- **SI** common



Phillips. *Understanding body dysmorphic disorder : an essential guide*. 2009; Bjornsson. *Dialogues Clin Neurosci. 2010*; Phillips. *J Clin Psychiatry.* 2005; Didie. *Compr Psychiatry.* 2008

# Diagnosis of BDD in DSM-5

- Preoccupation with perceived defects in physical appearance that are not observable or appear slight to others
- Individual performs repetitive behaviors (e.g. mirror checking) or mental acts (e.g. comparing appearance) in response to concerns
- Causes significant distress or impairment
- **Not better explained by an eating disorder** (e.g. concerns with body fat or weight

*Specify **insight:** good/fair, poor, or absent/delusional*

# Treatment of BDD

- Studies limited
- **~75% of BDD pts seek cosmetic treatments** which only rarely improve BDD sx
- Pts with BDD much **more likely to sue** their surgeons
- 4 surgeons murdered by pts with BDD
- **SSRIs** and **CBT** are first-line treatments



Phillips. *Psychosomatics.* 2001; Crerand. *Psychosomatics.* 2005; Sarwer. *Aesthet. Surg. J.* 2002; Crerand. *Plast. Reconstr. Surg.* 2006; Yazel LT. *Glamour.* 1999

# SRIs for BDD

- Serotonin reuptake inhibitors **(SRIs) effective**
  - Clomipramine, ~140 mg/d, RCT (tricyclic)
  - Fluoxetine, ~80 mg/d, RCT
  - Escitalopram, ~30 mg/d, open-label study and RCT
  - Citalopram, ~50 mg/d, open-label study
  - Fluvoxamine, ~210-240 mg/d, two open-label studies

- No direct comparative studies, SRIs thought to be **equally effective**



Hollander. *Arch Gen Psychiatry.* 1999; Phillips. *Arch Gen Psychiatry,* 2002; Phillips. *Int Clin Psychopharmacol.* 2006; Phillips. *Am J Psychiatry.* 2016; Phillips & Najjar. *Clin Psychiatry. 2003*; Perugi. *Int Clin Psychopharmacol.* 1996; Phillips. *Clin Psychiatry. 1998*; Phillips & Hollander. *Body Image*. 2008

# Which SRI for BDD?

SRIs thought to be equally effective but due to **high dose** requirements in BDD, SRIs with **lower side effect profiles typically trialed first**

| | Drug Name | Target Dose | Advantages | Disadvantages |
|---|---|---|---|---|
| SSRI | **Escitalopram** | 20 mg/d | well-tolerated | |
| | **Sertraline** | 200 mg/d | well-tolerated | |
| | **Fluoxetine** | 80 mg/d | well-tolerated, long half-life, activating | drug interactions |
| | **Citalopram** | 40 mg/d | well-tolerated | potential ⇧QTc, Reduced **max dose may not be sufficient in BDD** |
| | **Paroxetine** | 60 mg/d | | **sedation, weight gain, short half-life** |
| | **Fluvoxamine** | 300 mg/d | | **sedation, weight gain** |
| | **Clomipramine** | 250 mg/d | | **sedation, constipation, urinary retention, HoTN, ⇧QTc, seizures, drug interactions, weight gain Considered second-line** |

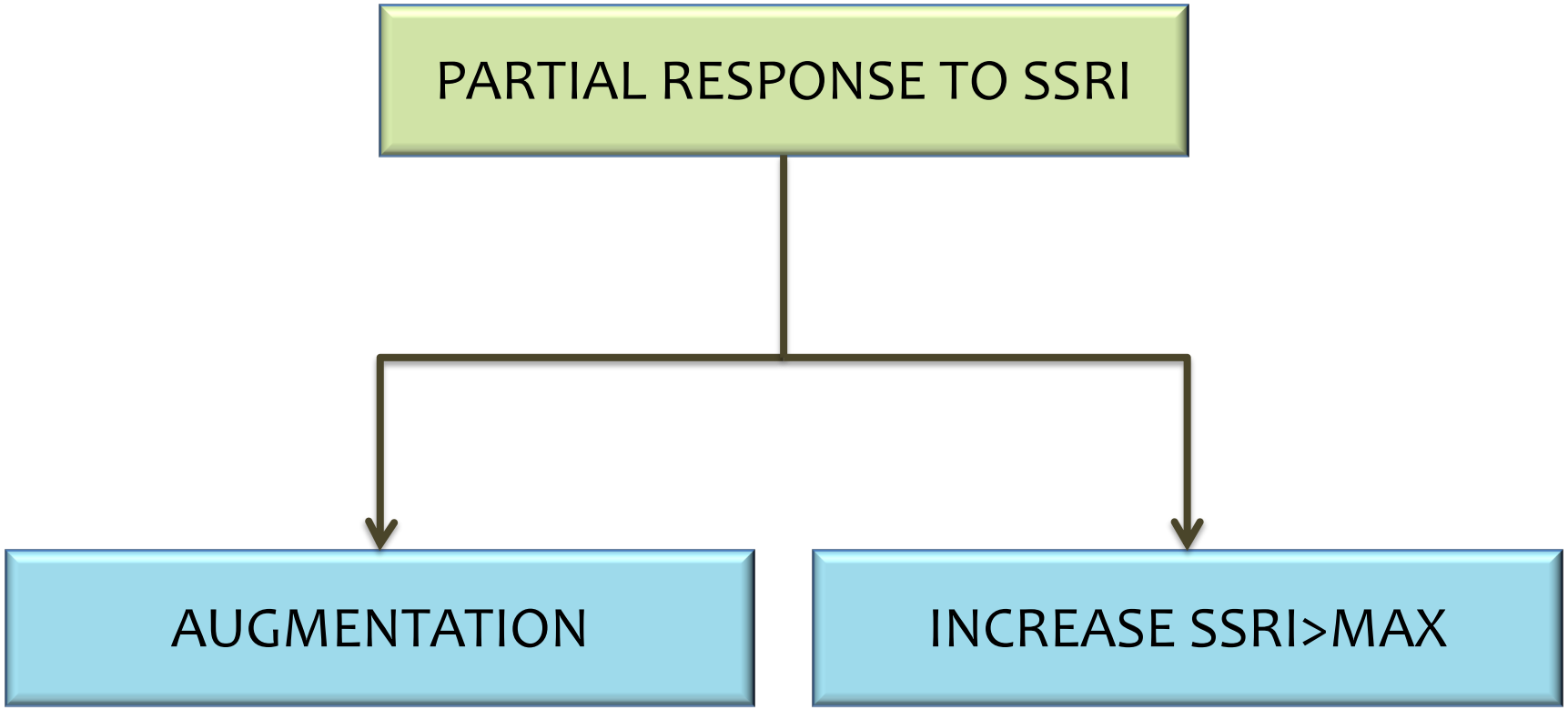
# SSRI trial in BDD

- **High doses** (max or >max) often required
- **Response delayed** (4-6 wks for initial effect, 10-12 wks for full effect)
- **Trial length: 12 wks** (4-6 wks at the maximum tolerable dose)
- **Rapid titration** recommended
- Duration of treatment (not well-studied)
  - Only one relapse study to date, 40% relapse if SSRI stopped <6 mo
  - given lethality of BDD, **SSRI recommended several years or longer**



Phillips & Hollander. *Body Image*. 2008; Phillips. *Am J Psychiatry.* 2016

# Approach to partially effective SSRI



# SSRI augmenting agents in BDD

- Limited studies, very **few options**
- **Buspirone** (60 mg TDD) shows benefit in open-label & chart-review study
- Atypical antipsychotics-not well studied but often used
  - **Aripiprazole**, beneficial in 1 case report, 10 mg/d
  - **Risperidone,** beneficial in 1 case report, 4 mg/d
  - Olanzapine, mixed case reports (2 robust, 6 no effect), ~5 mg/d
  - In chart review study, only 15% respond to antipsychotic augmentation but effect size large
  - Typical antipsychotic pimozide, not efficacious in RCT
- **Clomipramine**, beneficial in 4 case reports, ~125 mg/d
  - Start low dose (25-50 mg) and monitor EKG and level while titrating



Phillips. *Psychopharmacol Bull.* 1996; Uzun. *Clin Drug Investig*. 2010; Grant. *J Clin Psychiatry*. 2001; Phillips. *Am J Psychiatry*. 2005; Goulia. *Hippokratia.* 2011: Nakaaki. *Psychiatry Clin Neurosci*. 2008; Phillips. *Am J Psychiatry.* 2005; Phillip. *J Clin Psychiatry*.2001

# Higher than max SSRI dosing in BDD

| Drug | FDA Max Dose | Reported BDD >max dosing | My max dosing | Notes |
|---|---|---|---|---|
| **Escitalopram** | 20 mg/d | Up to 50 mg/d | 30 mg/d | Check EKG |
| **Sertraline** | 200 mg/d | Up to 400mg/d | 300mg/d | |
| **Fluoxetine** | 80 mg/d | Up to 100mg/d | 120 mg/d | |
| **Paroxetine** | 60 mg/d | Up to 100mg/d | 80 mg/d | |
| **Fluvoxamine** | 300 mg/d | Up to 400 mg/d | | |
| **Citalopram** | 40 mg/d | Up to 100mg/d | 80 mg/d | High dosing controversial given QTc prolongation risk, I consider with EKG, h/o failed medication trials, pt consent |
| **Clomipramine** | 250 mg/d | | | Above max dosing not recommended due to seizure risk |

No guidelines on above maximum dosing in BDD exist – doses circled are generally well-tolerated in my practice



Phillips. *The Broken Mirror.* 2005

# Sexual AEs

- **Wait** (sexual AEs can take 1-2 mo to improve)
- **Add bupropion** (not FDA-approved)
  - Dose-dependent,  2 RCTs, bupropion SR 150 mg daily ineffective, but 150 mg PO BID beneficial
  - Bupropion should not be combined with clomipramine given seizure risk
- **Add Maca root** (not FDA-approved), OTC
  - 2 RCTs for antidepressant-induced sexual dysfunction (men, women)
  - 500 mg PO BID x7d, then 1000 mg PO BID x7d, then 1500 mg PO BID
  - Check  TSH ~1 mo after starting
- **Add buspirone** (not FDA-approved)
  - Beneficial in RCT, ~48 mg TDD
- For ED, **add sildenafil** (or equivalent)
- **Reduce SSRI** or **switch** to different SSRI
- **Flibanserin should not be combined with an SSRI**




DeBattista. *J Clin Psychiatry.* 2005; Masand. *Am J Psychiatry.* 2001; Safarinejad. *J Psychopharmacol.* 2011; Landén. *J Clin Psychopharmacol.* 1999; Dording. *CNS Neurosci Ther.* 2008; Dording. *Based Complement Alternat Med*. 2015

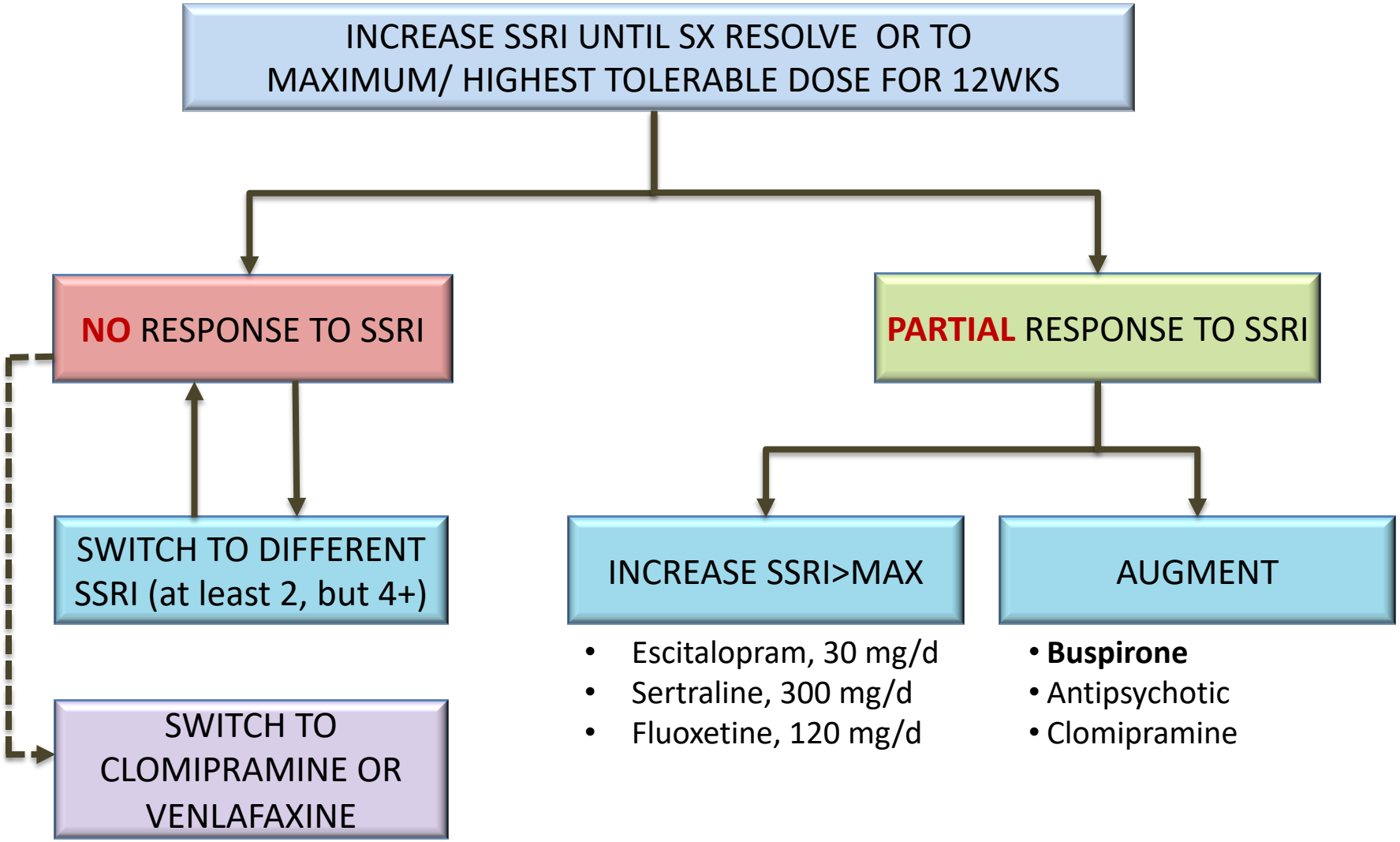
# Limited alternatives to SSRIs in BDD

- **Clomipramine,** beneficial in RCT, ~140 mg/d, but second-line due to AEs
- SNRIs
  - Being evaluated in BDD given efficacy in OCD but studies limited
  - **Venlafaxine,** effective in small open-label study, ~150-225 mg/d
  - **Duloxetine**, not yet studied, sometimes used, option for pts with pain
- Levetiracetam effective in small open-label study, ~1000mg PO BID



Hollander. *Arch Gen Psychiatry.* 1999; Allen. *CNS Spectr, 2008*; Phillips & Menard. CNS Spectr. 2009

# Suggested medication approach to BDD






Phillips. *Psychiatr Ann.* 2010

# CBT for BDD

## Cognitive restructuring

- **Challenge negative thoughts** related to appearance

## Response (ritual) prevention

- **Limit BDD repetitive behaviors** (e.g. mirror checking)

## Behavioral experiments

- **Carry out experiments** to evaluate the accuracy of beliefs about appearance

## Exposures

- **Face situations** which might normally be avoided

➢ RCT comparing CBT to waitlist shows 81% responder rate with CBT



Rosen. *J Consult Clin Psychol. 1995*; Veale. *Behav Res Ther,* 1996; Wilhelm. *Cognitive and Behavioral Practice, 2010;* Wilhelm S. *Behav Ther, 2010*; Wilhelm. *Cognitive-behavioral therapy for body dysmorphic disorder : a treatment manual*. 2013; Wilhelm. *Behav Ther.* 2014

# Delusional BDD

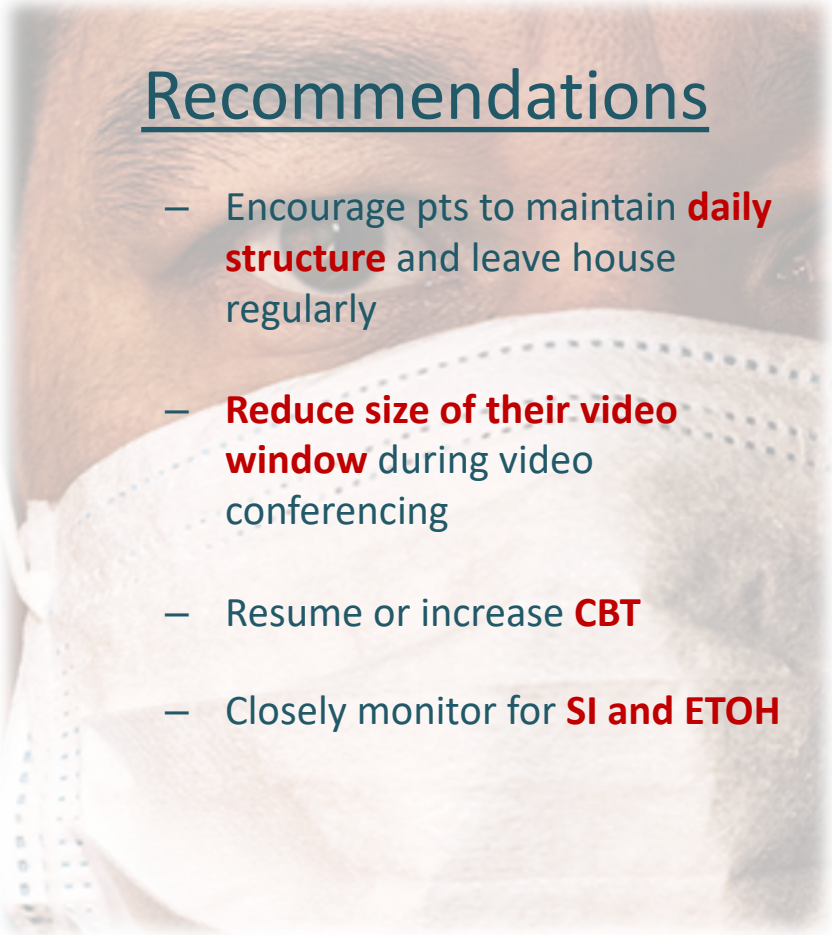
- Medication:
  - **Antipsychotic monotherapy NOT proven to be effective**
  - **SSRIs are effective** for pts with delusional BDD and considered first-line
  - For those lacking insight into BDD, pitch SSRI to other psychiatric sx (e.g depression, anxiety)
- Monitor closely for **SI**
- Try to **delay planned cosmetic procedures**



Phillips & Feusner. *Psychiatr Ann.* 2010; Phillip. *Psychopharmacol Bull.* 1994; Hollander. *Arch Gen Psychiatry.* 1999; Phillips. *Arch Gen Psychiatry.* 2002; Phillips. *Int Clin Psychopharmacol.* 2006; Phillips. *J Clin Psychiatry*. 2003; Phillips. *J Clin Psychiatry.* 2001

# BDD and COVID-19

- ↑BDD w/ pandemic
  - **Prolonged view of self** during video meetings
  - **Zoom filters** can create idealized images **("snapchat dysmorphia")**
  - Reduced structure/working from home can increase time for **repetitive behaviors**
    - Excessively researching cosmetic treatments
    - Comparing oneself to online images
    - Increased mirror checking
  - **Reduced exercise** due to gym closures
  - Isolation, increases risk for **SI/substance use**



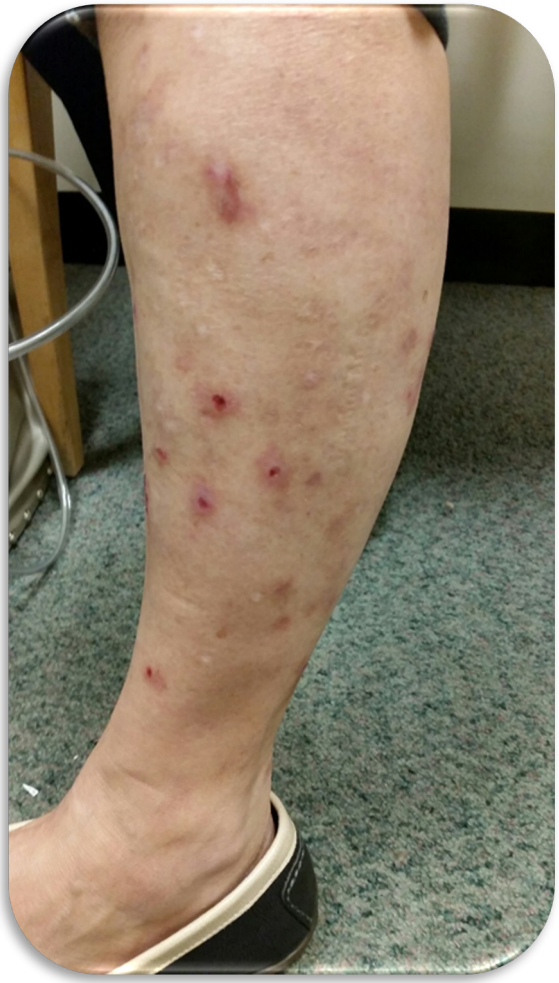
## Recommendations

- Encourage pts to maintain **daily structure** and leave house regularly
- **Reduce size of their video window** during video conferencing
- Resume or increase **CBT**
- Closely monitor for **SI and ETOH**

# Excoriation (Skin-Picking) Disorder

# Clinical features of skin picking

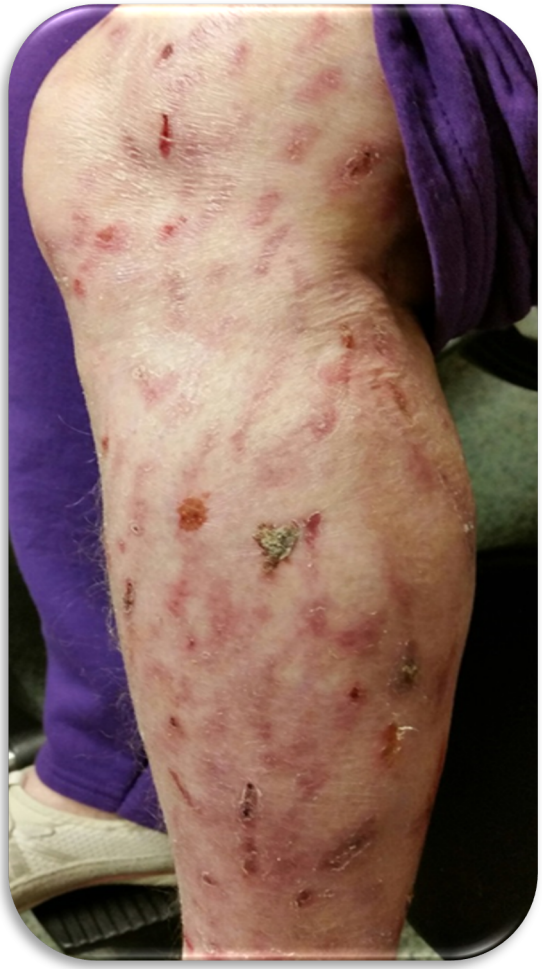
- Prevalence 1.4-5.4%
- Women>>men
- <20% of pts who pick actually seek treatment
- Triggers
  - Removing a blemish
  - Coping with negative emotions (depression, anger, anxiety)
  - **Boredom/idle hands (↑ w/ work from home during pandemic)**
  - Itch
  - Pleasure
- Varying degrees of self-awareness
  - **Focused picking**
  - **Automatic picking**





Keuthen. *Compr Psychiatry. 2010*; Hayes. *J Anxiety Disord.* 2009;Grant. *Am J Psychiatry.* 2012; Grant. *Trichotillomania, skin picking, and other body-focused repetitive behaviors*. 1st ed. 2012

# Complications



- Scarring/disfigurement
- Avoidance
- Social and occupational dysfunction
- Cellulitis/sepsis
- Excessive blood loss
- Paralysis



Grant. *Am J Psychiatry.* 2012; Grant. *Trichotillomania, skin picking, and other body-focused repetitive behaviors*. 1st ed. 2012; Flessner & Woods. *Behav Modif.* 2006

# Diagnosis of skin picking D/O in DSM-5

- Recurrent skin picking resulting in skin lesions
- Repeated attempts to stop picking
- Causes **significant distress or impairment**
- **Not due to a substance** (e.g. amphetamine, cocaine)
  - Substance-induced OCRD, e.g. Cocaine-induced OCRD
- **Not due to a medical condition** (e.g. HoTH, liver disease, uremia, lymphoma, HIV, scabies, atopic dermatitis, blistering skin disorders)
  - OCRD due to a medical condition, e.g. OCRD due to HIV with skin picking
- **Not secondary to another mental disorder** (e.g. delusions of parasitosis)

# Treatment of skin picking

- Clinically, **CBT considered first-line** but no studies comparing meds to CBT
- Medication studies limited, **SSRIs and N-acetylcysteine** effective
- Consider dermatology referral
  - Skin care
  - Treatment of dermatologic triggers for picking (e.g. acne, itch)
- For **moderate-severe cases** or if indicated by clinical hx, **check labs**
  - CBC
  - CMP
  - TSH
  - Tox screen
  - +/- HIV



Selles. *Gen Hosp Psychiatry*. 2016

# CBT for skin picking (and hair pulling)

## Habit reversal

- Awareness training- identify stimuli for picking or pulling
- Competing response- replace picking/pulling with harmless motor behavior

## Cognitive restructuring

- Challenge maladaptive thoughts related to picking/pulling

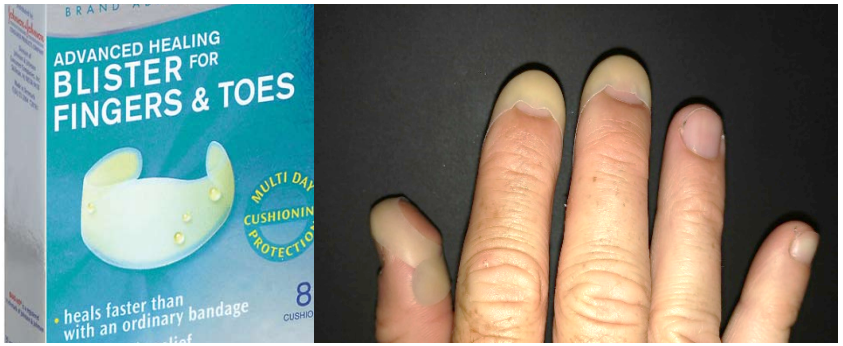
## Stimulus control

- Modify environment to reduce opportunities to pick skin or pull hair (e.g. wear gloves)

➢ RCT of HRT vs waitlist for skin picking shows 77% reduction in picking in HRT group, 16% WL

Grant. *Trichotillomania, skin picking, and other body-focused repetitive behaviors*. 1st ed. 2012; Woods. *Tic disorders, trichotillomania, and other repetitive behavior disorders : behavioral approaches to analysis and treatment*. 2001; Deckersbach. *Behav Modif, 2002*; Teng. *Behav Modif. 2006*; Woods & Twohig. *Trichotillomania : an ACT-enhanced behavior therapy approach : therapist guide*. 2008; Siev. Assessment and treatment of pathological skin picking. In *Oxford Handbook of Impulse Control Disorders,* 2012, Teng. *Behav Modif*. 2006

# Stimulus control






http://store.trich.org/

# New device for awareness training


https://www.habitaware.com/

# First-line medications for skin picking

- **SSRIs**
  - Limited data, but multiple studies showing that **SSRIs can reduce skin picking**
    - Fluoxetine, 2 positive RCTs (~55 mg/d, ~80mg/d)
    - Fluvoxamine (~110 mg/d), positive open label study
    - Escitalopram (~25 mg/d), positive open-label study
    - Sertraline (~100 mg/d), large case series (n=31) with 68% response rate
    - Citalopram 20 mg/d did not different from placebo in RCT but study was only 4 weeks and likely too short
  - No direct comparative studies, **SSRIs thought to be equally effective**
  - Unlike BDD and OCD, response not delayed, standard **8 wk trial** advised

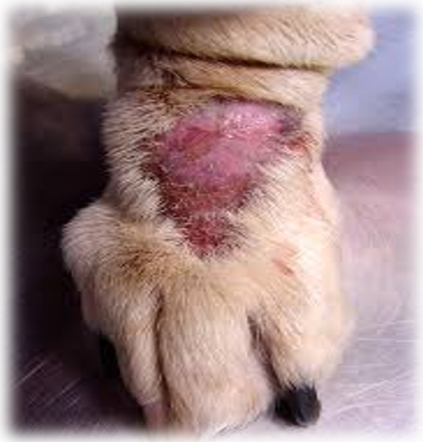
- **N-acetylcysteine (NAC)**
  - OTC glutamatergic modulator
  - Addiction, gambling, OCD, schizophrenia, BPAD
  - Significant improvement in RCT of pts w/ skin picking and RCT of hair pulling
  - Beneficial in open-label study of skin picking in pts w/ Prader-Willi syndrome
  - Start 600 mg PO BID x 2 wks, then **1200 mg PO BID (>6 week trial)**
  - **Preferred to SSRI if no comorbid depression or anxiety**



Simeon. *J Clin Psychiatry.* 1997; Bloch. *Psychosomatics,* 2001; Arbabi. *Acta Med Iran* 2008; Arnold. *J Clin Psychopharmacol,* 1999; Keuthen. *J Int Clin Psychopharmacol,* 2007; Kalivas. *Arch Dermatol*. 1996; Grant. *JAMA Psychiatry.* 2016; Miller & Angulo. *Med Genet A.* 2014, Lochner C.*Neuropsychiatr Dis Treat*. 2017

# Other medications for skin picking

- **Naltrexone,** 50-100 mg/d
  - Opioid antagonist used in ETOH and opioid use, kleptomania, gambling
  - Only 2 case reports but often used given benefit in TTM & canine acral lick dermatitis
  - Hepatotoxicity with doses >300 mg/d, check LFTs 1m, 3m, 6m, yearly



- Mood stabilizers
  - **Topiramate,** 25-200 mg/d (open-label study, n=10), robust improvement
  - Lithium, 300-900 mg/d (case series, n=2)

- Atypical antipsychotics
  - Limited data but used given benefit in TTM
  - **Aripiprazole,** 5-10 mg/d (3 case reports)
  - Olanzapine, 5 mg/d (case report)
  - Risperidone, 1.5 mg/d (case report)

- Treatments for itch
  - **Gabapentin** (~100-1800 mg/d) **or pregabalin** (75-300 mg/d) can reduce itch, reviewed in Matsuda 2016
  - Hydrating lotion (e.g. hydrolatum, OTC); consider referral to derm for topical steroids, topical/oral antihistamines, etc.

- Others
  - Silymarin, from milk thistle, 150-300mg PO BID (case series, n=3), serious drug interactions
  - Inositol, 6g PO TID (case series, n=3), taken in powder form
    - Titration; https://www.bfrb.org/learn-about-bfrbs/treatment/self-help/120-inositol-and-trichotillomania
  - Riluzole, 100mg PO BID, (case report), LFTs/CBC must be monitored given rare neutropenia and hepatitis, advise pt to report any febrile illness

Benjamin & Buot-Smith. *Am Acad Child Adolesc Psychiatry. 1993*; Banga. *Child Adolesc Psychopharmacol.* 2012; Christensen. *Can J Psychiatry*. 2004; Jafferany. *Prim Care Companion CNS Disord.* 2017. Curtis & Richards. *Ann Clin Psychiatry*. 2007; Carter. *J Clin Psychiatry*. 2006; Turner. *Innov Clin Neurosci.* 2014; Gupta.*Clin Dermatol*. 2013; Sasso. *J Clin Psychopharmacol.* 2006; Grant & Odlaug. *J Clin Psychopharmcol.* 2015; Seedat. *J Clin Psychiatry.* 2001; Matsuda. *J Am Acad Dermatol*. 2016

# Trichotillomania (TTM)

# Clinical features of TTM

- ~0.6-3.4% prevalence
- Women>>men
- Most often on scalp and eyebrows but may be anywhere including lashes, pubic hair, and others
- Hours daily
- Shame and avoidance
- Triggers: **idle hands**, anxiety, depression, anger, aesthetics, hairs not feeling right



Grant. *Trichotillomania, skin picking, and other body-focused repetitive behaviors*. 1st ed. 2012; Duke. *Clin Psychol Rev.* 2010; Duke. *J Anxiety Disord.* 2009; O'Sullivan. *Psychiatr Clin North Am.* 2000

# Diagnosis of TTM in DSM-5

- Recurrent hair pulling resulting in hair loss
- Repeated attempts to stop pulling
- Causes **significant distress or impairment**
- Hair pulling not secondary to medical condition or mental disorder (e.g. OCD)

# Treatment of TTM

- **CBT considered first-line** with ~65-70% response rate
- Medication studies limited: **NAC, olanzapine, and clomipramine** can help
- **CBT more effective than meds (clomipramine/fluoxetine)** in comparator studies but studies limited

Response rates in TTM

| | Therapy | Waitlist | Medication |
|---|---|---|---|
| Ninan, 2000 | CBT **71%** | (Placebo) **0%** | Clomipramine 100mg/d **40%** |
| Van Minnen, 2003 | BT **64%** | **20%** | Fluoxetine 60mg/d **9%** |

(BT, behavioral therapy)



van Minnen. *Arch Gen Psychiatry.* 2003; Ninan. *J Clin Psychiatry.* 2000; Woods. *Behav Res Ther.* 2006

# First-line medications for TTM

- **N-acetylcysteine (NAC)**, 1200 mg PO BID
  - Significantly improves TTM in single RCT (56% response rate)
  - OTC, 600mg PO BID x 2 wks, then 1200mg PO BID
- **Olanzapine,** ~10 mg/d
  - Significantly improves TTM in single RCT (85% response rate)
  - Use tempered by long-term metabolic risks
- **Clomipramine,** ~100-180mg/d (mixed results)
  - Double blind crossover study of TTM showed CMI >> desipramine (~180 mg/d)
  - In placebo-controlled RCT, CMI doesn't differentiate from placebo (~100 mg/d)
  - Meta-analysis: clomipramine effect size .68 (moderate), habit reversal therapy effect size 1.41 (large), SSRI effect size .02 (none)



Grant. *Archives of General Psychiatry.* 2009; Van Ameringen. *J Clin Psychiatry. 2010;* White & Koran. *J Clin Psychopharmacol*. 2011; Swedo. *NEJM.* 1989; Ninan. *J Clin Psychiatry.* 2000; Bloch. *Biol Psychiatry.* 2007

# SSRIs generally ineffective in TTM

- **No change in hair pulling in 3 RCTs** (fluoxetine x 2, sertraline)
- No change in open-label trial of fluvoxamine
- Meta-analysis: **SSRI effect size .02 (none)**, habit reversal therapy effect size 1.41 (large)

**HOWEVER, SSRIs are sometimes prescribed** when anxiety/depression are clear triggers for pulling and can be helpful in isolated cases



Christenson. *AJP.* 1991; Streichenwein & Thornby, *AJP* 1995; Rothbart. *Cochrane Database Syst Rev.* 2013; Stanley. *J Clin Psychopharmacol.* 1997; Bloch. *Biol Psychiatry.* 2007

# Other medications for TTM

- **Naltrexone**, 50-100 mg/d
  - Mixed results in TTM
  - Beneficial in small RCT of adult TTM but no effect in larger RCT; specifically effective for pts with FH of addiction
  - Monitoring: hepatotoxicity with doses >300 mg/d, LFTs 1m, 3m, 6m, yearly

- Open-label studies
  - **Topiramate** (n=14), ~160 mg/d
  - **Aripiprazole** (n=12), ~7.5 mg/d, 58% response rate, alternative to olanzapine
  - **Dronabinol** (n=14), 2.5-5 mg PO BID, RCT ongoing now

- Other options
  - **Lithium** (case series, n=10), 900-1500 mg/d
  - **Bupropion XL** (case series, n=2), 300-450 mg/d
  - **Inositol,** (case series n=3 but not recent RCT), 6g PO TID
    - Titration; https://www.bfrb.org/learn-about-bfrbs/treatment/self-help/120-inositol-and-trichotillomania



O'Sullivan. *Trichotillomania,* 1999 (pg 93-124); Grant. *J Clin Psychopharmacol*. 2014; Lochner. *International Clinical Psychopharmacology*. 2006; Grant. *Psychopharmacology* 2011; White. *J Clin Psychopharmacol*. 2011; Christenson. *J Clin Psychiatry.* 1991; Grant. *J Clin Psychopharmcol.* 2015; Klipstein. *J Clin Psychopharmacol.* 2012; Seedat. *J Clin Psychiatry.* 2001; Leppink. *Int Clin Psychopharmacol.* 2017

# Additional management options

- Waterproof eyebrow stamps
- Magnetic false eyelashes
- Hairpieces/wig
- Toppik
- Hairdressers specializing in TTM
- Trichotillomania learning center (TLC) support groups-bfrb.org

# Hoarding Disorder

# Hoarding

- Difficulty discarding items
- Significant clutter
- Often includes excessive acquisition
- 2-6% prevalence, men=women
- Variable insight
- Health problems from dust, mold, or pests
- Injury/death from falling items, structural dangers, fire
- Removal of children/dependent adults
- Homelessness due to eviction
- Risks to neighbors

Mataix-Cols. *N Engl J Med.* 2014; Steketee & Frost. *Treatment for Hoarding Disorder : Therapist Guide*. 2nd Ed. 2013; Frost. *Depress Anxiety.* 2011. Shadwulf (2001). Hoarding Living Room. [Photo]. From http://commons.wikimedia.org/wiki/File:Hoarding_living_room.jpg, Schmalisch (n.d.) Addressing Housing Issues. From https://hoarding.iocdf.org/addressing-housing-issues/

# Diagnosis of hoarding in DSM-5

- Persistent difficulty discarding items regardless of value
- Difficulty due to need to save items and distress associated with discarding them
- Hoarding leads to **clutter in active living areas**
- Causes significant distress or impairment
- Hoarding not due to medical condition (e.g. Prader-Willi syndrome) or another mental condition (MDD, OCD)
  - *Specify if with excessive acquisition*
  - *Specify insight: good/fair, poor, or absent/delusional*

# Assessing severity/safety

- Clutter Image Rating Scale **(CIR)**
- Activities of Daily Living-Hoarding Scale **(ADL-H)**
- **Dependents/animals**
- **Eviction**




Steketee & Frost. *Compulsive hoarding and acquiring: A therapist guide*. 2007; Steketee & Frost. *Treatment for Hoarding Disorder : Therapist Guide*. Second Ed. 2013; Frost. Obsessive Compuls Relat Disord. 2013. Clutter Image Rating. (n.d.). [Photo] . From http://global.oup.com/us/companion.websites/umbrella/treatments/hidden/pdf/CIR_photos.pdf with permission from Dr. Steketee

# Treatment of hoarding

**CBT** is main treatment, no well-established medication treatments

## Skills training

- Plan **categories for unwanted objects**
- Plan categories and final locations for wanted objects

## Cognitive restructuring

- Identify and **challenge beliefs that maintain hoarding**

## Exposure to discarding and nonacquiring

- Make discarding hierarchy, start with items that are least anxiety-provoking
- Make **non-acquisition trips**

➢ RCT of CBT vs. waitlist, 41% show significant clinical improvement w/ large effect sizes on hoarding scales



Steketee & Frost. *Treatment for Hoarding Disorder : Therapist Guide*. Second Ed. 2013; Steketee. *Depress Anxiety*. 2010

# Medication treatment of hoarding

- Meds **(SSRIs) thought to be ineffective** but being reconsidered
- **Earlier studies not representative**: excluded pts w/ hoarding who did not have other OCD sx
- Recent open-label studies w/o this exclusion **show medication benefit:**

| Drug | Mean dose | UCLA Hoarding Severity Scale reduction | Partial responders | Full Responders |
|---|---|---|---|---|
| **Paroxetine (n=79)** | 40 mg/d | 31% | **50%** | 28% |
| **Venlafaxine (n=24)** | 200 mg/d | 36% | **70%** | 32% |
| **Atomoxetine (n=11)** | 60 mg/d | 41% | **81%** | 54% |

- **Paroxetine/venlafaxine XR accelerate response** from 26 wks (CBT)>12 wks
- Small case series (n=4, DSM-5 hoarding criteria) of **methylphenidate ER** (~50 mg/d): 50 % show modest reduction in hoarding sx despite not having ADHD
- No medication RCTs in hoarding ongoing; consider trial of atomoxetine, venlafaxine, or SSRI based on above prelim data



Saxena. *J Psychiatr Res. 2007*; Saxena. J *Int Clin Psychopharmacol.* 2014; Grassi G, *J Psychiatr Res.* 2016

# Treatment tips for hoarding


Forced interventions not recommended

Team approach

- family
- local hoarding task forces
- Tenancy Prevention Program
- Groups-MassHousing



Steketee G and Frost R. *Treatment for Hoarding Disorder : Therapist Guide*. Second Edition. 2013; Hoarding: Buried Alive, Season 3. [Photo]. (n.d.). From: https://itunes.apple.com/us/tv-season/hoarding-buried-alive-season/id446202854

# Resources

- **Patient/provider education, self-help**
  - ***Understanding Body Dysmorphic Disorder*** by Katharine Phillips (comprehensive overview for pts, families, and clinicians)
  - ***Feeling Good About the Way You Look*** by Sabine Wilhelm (self-guided CBT for BDD)
  - ***CBT for BDD, Treatment Manual*** by Sabine Wilhelm et al. (therapist guide)
  - **TLC Foundation for Body-Focused Repetitive Behaviors,** www.bfrb.org
  - ***TTM, Skin Picking, & Other Body-Focused Repetitive Behaviors*** by Jon Grant et al. (comprehensive overview for pts and providers)
  - ***Help for Hair Pullers*** by Nancy Keuthen (self-guided CBT)
  - ***Treatment of Hoarding*** by Gail Steketee and Randy Frost (CBT guide for therapists)
  - ***Buried in Treasure*** by David Tolin et al. (self-guided CBT for hoarding)
  - Free mobile apps: **TrichStop, SkinPick;** Online treatment: **www.trichstop.com, www.skinpick.com , StopPicking.com, StopPulling.com**

# Resources (cont.)

- **Finding specialists**
  - **MGH OCD and Related Disorders Program**, https://mghocd.org/
  - **International OCD Foundation**, www.iocdf.org
  - **TLC Foundation for Body-Focused Repetitive Behaviors**, www.bfrb.org
  - **IOCDF Hoarding Center**, hoarding.iocdf.org
  - **Mass Housing**, MassHousing.com/hoarding (excellent local and national hoarding resources)
  - **Regional hoarding task forces**, https://www.masshousing.com/portal/server.pt/document/2697/massachusetts_local_hoarding_task_forces
  - **MA hoarding directory**, https://www.masshousingrental.com/portal/server.pt/document/11093/hoarding_resource_directory_pdf , (list of mental health professionals, professional organizers, and emergency clean out services)
  - **Tenancy Prevention Program:** https://www.mass.gov/info-details/tenancy-preservation-program

- **Residential treatment**
  - **McLean OCDI Institute,** www.mcleanhospital.org/programs/ocd-institute-ocdi
  - **Rogers OCD Center**, rogersbh.org/what-we-treat/ocd-anxiety/ocd-and-anxiety-residential-services/ocd-center
  - **Houston OCD Program**, houstonocdprogram.org/residential-support-program/