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.

Obsessive-compulsive personality disorder. 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 intrusions; 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 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%]). Onset of OCD is usually later than for most comorbid anxiety disorders (with the exception of separation anxiety disorder) and PTSD but often precedes that of depressive disorders. Comorbid obsessive-compulsive personality disorder is also common in individuals with OCD (e.g., ranging from 23% to 32%).

Up to 30% of individuals with OCD also have a lifetime tic disorder. A comorbid tic disorder 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. A triad of OCD, tic disorder, and attention-deficit/hyperactivity disorder can also be seen in children.

Disorders that occur more frequently in individuals with OCD than in those without the disorder include several obsessive-compulsive and related disorders such as body dysmorphic disorder, trichotillomania (hair-pulling disorder), and excoriation (skin-picking) disorder. Finally, an association between OCD and some disorders characterized by impulsivity, such as oppositional defiant disorder, has been reported.

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; and Tourette's disorder.

Body Dysmorphic Disorder

Diagnostic Criteria **300.7 (F45.22)**

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

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

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

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

Specify if:

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

Specify if:

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

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, time-consuming (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; excessively grooming (e.g., combing, styling, shaving, plucking, or pulling hair); camouflaging (e.g., repeatedly applying makeup or covering disliked areas with such things as a hat, clothing, makeup, or 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. 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.

Muscle dysmorphia, a form of body dysmorphic disorder occurring almost exclusively in males, 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. 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.

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 their appearance is accurate and undistorted). On average, insight is poor; one-third or more of individuals currently have delusional body dysmorphic disorder beliefs. Individuals with delusional body dysmorphic disorder tend to have greater morbidity in some areas (e.g., suicidality), but this appears accounted for by their tendency to have more severe body dysmorphic disorder symptoms.

Associated Features Supporting Diagnosis

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, neuroticism, and perfectionism as well as low extroversion and low self-esteem. 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. Occasionally, individuals may 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 because they are dissatisfied with the cosmetic outcome.

Body dysmorphic disorder has been associated with executive dysfunction and visual processing abnormalities, with a bias for analyzing and encoding details rather than holistic or configural aspects of visual stimuli. Individuals with this disorder tend to have a bias for negative and threatening interpretations of facial expressions and ambiguous scenarios.

Prevalence

The point prevalence among U.S. adults is 2.4% (2.5% in females and 2.2% in males). Outside the United States (i.e., Germany), 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.

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. Two-thirds of individuals have disorder onset 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 are more likely to attempt suicide, have more comorbidity, and have gradual (rather than acute) disorder onset than those with adult-onset body dysmorphic disorder.

Risk and Prognostic Factors

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

Genetic and physiological. The prevalence of body dysmorphic disorder is elevated in first-degree relatives of individuals with obsessive-compulsive disorder (OCD).

Culture-Related Diagnostic Issues

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. *Taijin kyofusho,* included in the traditional Japanese diagnostic system, has a subtype similar to body dysmorphic disorder: *shubo-kyofu* ("the phobia of a deformed body").

Gender-Related Diagnostic Issues

Females and males 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, males are more likely to have genital preoccupations, and females are more likely to have a comorbid eating disorder. Muscle dysmorphia occurs almost exclusively in males.

Suicide Risk

Rates of suicidal ideation and suicide attempts are high in both adults and children/adolescents with body dysmorphic disorder. Furthermore, risk for suicide appears high in adolescents. A substantial proportion of individuals attribute suicidal ideation or suicide attempts primarily to their appearance concerns. Individuals with body dysmorphic disorder have many risk factors for completed suicide, such as high rates of suicidal ideation and suicide attempts, demographic characteristics associated with suicide, and high rates of comorbid major depressive disorder.

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 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. Impairment in social functioning (e.g., social activities, relationships, intimacy), including avoidance, is common. Individuals may be housebound because of their body dysmorphic disorder symptoms, sometimes for years. A high proportion of adults and adolescents have been psychiatrically hospitalized.

Differential Diagnosis

Normal appearance concerns and clearly noticeable physical defects. Body dysmorphic disorder differs from normal appearance concerns in being characterized by exces-

sive 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.

Eating disorders. In an individual with an eating disorder, concerns about being fat 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.

Other obsessive-compulsive and related disorders. The preoccupations and repetitive behaviors of body dysmorphic disorder differ from obsessions and compulsions in OCD in that the former focus only on appearance. These disorders have other differences, such as poorer insight 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 or body hair, body dysmorphic disorder is diagnosed rather than trichotillomania (hair-pulling disorder).

Illness anxiety disorder. Individuals with body dysmorphic disorder are not preoccupied with having or acquiring a serious illness and do not have particularly elevated levels of somatization.

Major depressive disorder. 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.

Anxiety disorders. Social anxiety and avoidance are common in body dysmorphic disorder. However, unlike social anxiety disorder (social phobia), agoraphobia, and avoidant personality disorder, body dysmorphic disorder includes prominent appearance-related preoccupation, which may be delusional, and repetitive behaviors, and the social anxiety and avoidance are due 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.

Psychotic disorders. 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; however, unlike schizophrenia or schizoaffective disorder, body dysmorphic disorder involves prominent appearance preoccupations and related repetitive behaviors, and disorganized behavior and other psychotic symptoms are absent (except for appearance beliefs, which may be delusional).

Other disorders and symptoms. 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 or if the preoccupation focuses on the belief that one emits a foul or offensive body odor as in olfactory reference syndrome (which is not a DSM-5 disorder). Body identity integrity disorder

(apotemnophilia) (which is not a DSM-5 disorder) involves a desire to have a limb amputated to correct an experience of mismatch between a person's sense of body identity and his or her actual anatomy. However, the concern does not focus on the limb's appearance, as it would in body dysmorphic disorder. *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 much broader construct than, and is 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 of body dysmorphic disorder. Comorbid social anxiety disorder (social phobia), OCD, and substance-related disorders are also common.

Hoarding Disorder

Diagnostic Criteria **300.3 (F42)**

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

Specify if:

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

Specify if:

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

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

With absent insight/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.

Specifiers

With excessive acquisition. 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 difficulties discarding or parting with possessions, regardless of their actual value (Criterion A). The term *persistent* indicates a long-standing 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 these difficulties 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, old clothing, bags, books, mail, and paperwork, 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 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 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 due to a third-party intervention. Hoarding disorder contrasts with normative collecting behavior, which is organized and systematic, even if 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., 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). 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 Supporting Diagnosis

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 and 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. Most 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 be approximately 2%–6%. Hoarding disorder affects both males and females, but some epidemiological 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).

Development and Course

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, with few individuals reporting a waxing and waning course.

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

Temperamental. Indecisiveness is a prominent feature of individuals with hoarding disorder and their first-degree relatives.

Environmental. 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 behavior 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 behavior is attributable to additive genetic factors.