

(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)
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- 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.

Culture-Related Diagnostic Issues

While most of the research has been done in Western, industrialized countries and urban communities, the available data from non-Western and developing countries suggest that hoarding is a universal phenomenon with consistent clinical features.

Gender-Related Diagnostic Issues

The key features of hoarding disorder (i.e., difficulties discarding, excessive amount of clutter) are generally comparable in males and females, but females tend to display more excessive acquisition, particularly excessive buying, than do males.

Functional Consequences of Hoarding Disorder

Clutter impairs basic activities, such as moving through the house, cooking, cleaning, personal hygiene, and even sleeping. Appliances may be broken, and utilities such as water and electricity may be disconnected, as access for repair work may be difficult. Quality of life is often considerably impaired. In severe cases, hoarding can put individuals at risk for fire, falling (especially elderly individuals), poor sanitation, and other health risks. Hoarding disorder is associated with occupational impairment, poor physical health, and high social service utilization. Family relationships are frequently under great strain. Conflict with neighbors and local authorities is common, and a substantial proportion of individuals with severe hoarding disorder have been involved in legal eviction proceedings, and some have a history of eviction.

Differential Diagnosis

Other medical conditions. Hoarding disorder is not diagnosed if the symptoms are judged to be a direct consequence of another medical condition (Criterion E), such as traumatic brain injury, surgical resection for treatment of a tumor or seizure control, cerebrovascular disease, infections of the central nervous system (e.g., herpes simplex encephalitis), or neurogenetic conditions such as Prader-Willi syndrome. Damage to the anterior ventromedial prefrontal and cingulate cortices has been particularly associated with the excessive accumulation of objects. In these individuals, the hoarding behavior is not present prior to the onset of the brain damage and appears shortly after the brain damage occurs. Some of these individuals appear to have little interest in the accumulated items and are able to discard them easily or do not care if others discard them, whereas others appear to be very reluctant to discard anything.

Neurodevelopmental disorders. Hoarding disorder is not diagnosed if the accumulation of objects is judged to be a direct consequence of a neurodevelopmental disorder, such as autism spectrum disorder or intellectual disability (intellectual developmental disorder).

Schizophrenia spectrum and other psychotic disorders. Hoarding disorder is not diagnosed if the accumulation of objects is judged to be a direct consequence of delusions or negative symptoms in schizophrenia spectrum and other psychotic disorders.

Major depressive episode. Hoarding disorder is not diagnosed if the accumulation of objects is judged to be a direct consequence of psychomotor retardation, fatigue, or loss of energy during a major depressive episode.

Obsessive-compulsive disorder. Hoarding disorder is not diagnosed if the symptoms are judged to be a direct consequence of typical obsessions or compulsions, such as fears of contamination, harm, or feelings of incompleteness in obsessive-compulsive disorder (OCD). Feelings of incompleteness (e.g., losing one's identity, or having to document and preserve all life experiences) are the most frequent OCD symptoms associated with this form of hoarding. The accumulation of objects can also be the result of persistently avoid-

ing onerous rituals (e.g., not discarding objects in order to avoid endless washing or checking rituals).

In OCD, the behavior is generally unwanted and highly distressing, and the individual experiences no pleasure or reward from it. Excessive acquisition is usually not present; if excessive acquisition is present, items are acquired because of a specific obsession (e.g., the need to buy items that have been accidentally touched in order to avoid contaminating other people), not because of a genuine desire to possess the items. Individuals who hoard in the context of OCD are also more likely to accumulate bizarre items, such as trash, feces, urine, nails, hair, used diapers, or rotten food. Accumulation of such items is very unusual in hoarding disorder.

When severe hoarding appears concurrently with other typical symptoms of OCD but is judged to be independent from these symptoms, both hoarding disorder and OCD may be diagnosed.

Neurocognitive disorders. Hoarding disorder is not diagnosed if the accumulation of objects is judged to be a direct consequence of a degenerative disorder, such as neurocognitive disorder associated with frontotemporal lobar degeneration or Alzheimer’s disease. Typically, onset of the accumulating behavior is gradual and follows onset of the neurocognitive disorder. The accumulating behavior may be accompanied by self-neglect and severe domestic squalor, alongside other neuropsychiatric symptoms, such as disinhibition, gambling, rituals/stereotypies, tics, and self-injurious behaviors.

Comorbidity

Approximately 75% of individuals with hoarding disorder have a comorbid mood or anxiety disorder. The most common comorbid conditions are major depressive disorder (up to 50% of cases), social anxiety disorder (social phobia), and generalized anxiety disorder. Approximately 20% of individuals with hoarding disorder also have symptoms that meet diagnostic criteria for OCD. These comorbidities may often be the main reason for consultation, because individuals are unlikely to spontaneously report hoarding symptoms, and these symptoms are often not asked about in routine clinical interviews.

Trichotillomania (Hair-Pulling Disorder)

Diagnostic Criteria	312.39 (F63.3)
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- A. Recurrent pulling out of one’s hair, resulting in hair loss.
- B. Repeated attempts to decrease or stop hair pulling.
- C. The hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The hair pulling or hair loss is not attributable to another medical condition (e.g., a dermatological condition).
- E. The hair pulling is not better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder).

Diagnostic Features

The essential feature of trichotillomania (hair-pulling disorder) is the recurrent pulling out of one’s own hair (Criterion A). Hair pulling may occur from any region of the body in which hair grows; the most common sites are the scalp, eyebrows, and eyelids, while less common sites are axillary, facial, pubic, and peri-rectal regions. Hair-pulling sites may vary over time. Hair pulling may occur in brief episodes scattered throughout the day or during less frequent but more sustained periods that can continue for hours, and such hair

pulling may endure for months or years. Criterion A requires that hair pulling lead to hair loss, although individuals with this disorder may pull hair in a widely distributed pattern (i.e., pulling single hairs from all over a site) such that hair loss may not be clearly visible. Alternatively, individuals may attempt to conceal or camouflage hair loss (e.g., by using makeup, scarves, or wigs). Individuals with trichotillomania have made repeated attempts to decrease or stop hair pulling (Criterion B). Criterion C indicates that hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. The term *distress* includes negative affects that may be experienced by individuals with hair pulling, such as feeling a loss of control, embarrassment, and shame. Significant impairment may occur in several different areas of functioning (e.g., social, occupational, academic, and leisure), in part because of avoidance of work, school, or other public situations.

Associated Features Supporting Diagnosis

Hair pulling may be accompanied by a range of behaviors or rituals involving hair. Thus, individuals may search for a particular kind of hair to pull (e.g., hairs with a specific texture or color), may try to pull out hair in a specific way (e.g., so that the root comes out intact), or may visually examine or tactilely or orally manipulate the hair after it has been pulled (e.g., rolling the hair between the fingers, pulling the strand between the teeth, biting the hair into pieces, or swallowing the hair).

Hair pulling may also be preceded or accompanied by various emotional states; it may be triggered by feelings of anxiety or boredom, may be preceded by an increasing sense of tension (either immediately before pulling out the hair or when attempting to resist the urge to pull), or may lead to gratification, pleasure, or a sense of relief when the hair is pulled out. Hair-pulling behavior may involve varying degrees of conscious awareness, with some individuals displaying more focused attention on the hair pulling (with preceding tension and subsequent relief), and other individuals displaying more automatic behavior (in which the hair pulling seems to occur without full awareness). Many individuals report a mix of both behavioral styles. Some individuals experience an “itch-like” or tingling sensation in the scalp that is alleviated by the act of pulling hair. Pain does not usually accompany hair pulling.

Patterns of hair loss are highly variable. Areas of complete alopecia, as well as areas of thinned hair density, are common. When the scalp is involved, there may be a predilection for pulling out hair in the crown or parietal regions. There may be a pattern of nearly complete baldness except for a narrow perimeter around the outer margins of the scalp, particularly at the nape of the neck (“tonsure trichotillomania”). Eyebrows and eyelashes may be completely absent.

Hair pulling does not usually occur in the presence of other individuals, except immediate family members. Some individuals have urges to pull hair from other individuals and may sometimes try to find opportunities to do so surreptitiously. Some individuals may pull hairs from pets, dolls, and other fibrous materials (e.g., sweaters or carpets). Some individuals may deny their hair pulling to others. The majority of individuals with trichotillomania also have one or more other body-focused repetitive behaviors, including skin picking, nail biting, and lip chewing.

Prevalence

In the general population, 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.

Development and Course

Hair pulling may be seen in infants, and this behavior typically resolves during early development. Onset of hair pulling in trichotillomania most commonly coincides with, or follows the onset of, puberty. Sites of hair pulling may vary over time. The usual course of trichotillomania is chronic, with some waxing and waning if the disorder is untreated. Symptoms may possibly worsen in females accompanying hormonal changes (e.g., menstruation, perimenopause). For some individuals, the disorder may come and go for weeks, months, or years at a time. A minority of individuals remit without subsequent relapse within a few years of onset.

Risk and Prognostic Factors

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

Culture-Related Diagnostic Issues

Trichotillomania appears to manifest similarly across cultures, although there is a paucity of data from non-Western regions.

Diagnostic Markers

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

Functional Consequences of Trichotillomania (Hair-Pulling Disorder)

Trichotillomania is associated with distress as well as with social and occupational impairment. There may be irreversible damage to hair growth and hair quality. Infrequent medical consequences of trichotillomania include digit purpura, musculoskeletal injury (e.g., carpal tunnel syndrome; back, shoulder and neck pain), blepharitis, and dental damage (e.g., worn or broken teeth due to hair biting). Swallowing of hair (trichophagia) may lead to trichobezoars, with subsequent anemia, abdominal pain, hematemesis, nausea and vomiting, bowel obstruction, and even perforation.

Differential Diagnosis

Normative hair removal/manipulation. Trichotillomania should not be diagnosed when hair removal is performed solely for cosmetic reasons (i.e., to improve one's physical appearance). Many individuals twist and play with their hair, but this behavior does not usually qualify for a diagnosis of trichotillomania. Some individuals may bite rather than pull hair; again, this does not qualify for a diagnosis of trichotillomania.

Other obsessive-compulsive and related disorders. Individuals with OCD and symmetry concerns may pull out hairs as part of their symmetry rituals, and individuals with body dysmorphic disorder may remove body hair that they perceive as ugly, asymmetrical, or abnormal; in such cases a diagnosis of trichotillomania is not given. The description of body-focused repetitive behavior disorder in other specified obsessive-compulsive and related disorder excludes individuals who meet diagnostic criteria for trichotillomania.