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.

Culture-Related Diagnostic Issues

OCD occurs across the world. There is substantial similarity across cultures in the gender distribution, age at onset, and comorbidity of OCD. Moreover, around the globe, there is a similar symptom structure involving cleaning, symmetry, hoarding, taboo thoughts, or fear of harm. However, regional variation in symptom expression exists, and cultural factors may shape the content of obsessions and compulsions.

Gender-Related Diagnostic Issues

Males have an earlier age at onset of OCD than females and are more likely to have comorbid tic disorders. Gender differences in the pattern of symptom dimensions have been reported, with, for example, females more likely to have symptoms in the cleaning dimension and males more likely to have symptoms in the forbidden thoughts and symmetry dimensions. Onset or exacerbation of OCD, as well as symptoms that can interfere with the mother-infant relationship (e.g., aggressive obsessions leading to avoidance of the infant), have been reported in the peripartum period.

Suicide Risk

Suicidal thoughts occur at some point in as many as about half of individuals with OCD. Suicide attempts are also reported in up to one-quarter of individuals with OCD; the presence of comorbid major depressive disorder increases the risk.

Functional Consequences of Obsessive-Compulsive Disorder

OCD is associated with reduced quality of life as well as high levels of social and occupational impairment. Impairment occurs across many different domains of life and is associated with symptom severity. Impairment can be caused by the time spent obsessing and doing compulsions. Avoidance of situations that can trigger obsessions or compulsions can also severely restrict functioning. In addition, specific symptoms can create specific obstacles. For example, obsessions about harm can make relationships with family and friends feel hazardous; the result can be avoidance of these relationships. Obsessions about symmetry can derail the timely completion of school or work projects because the project never feels "just right," potentially resulting in school failure or job loss. Health consequences can also occur. For example, individuals with contamination concerns may avoid doctors' offices and hospitals (e.g., because of fears of exposure to germs) or develop dermatological problems (e.g., skin lesions due to excessive washing). Sometimes the symptoms of the disorder interfere with its own treatment (e.g., when medications are considered contaminated). When the disorder starts in childhood or adolescence, individuals may experience developmental difficulties. For example, adolescents may avoid socializing with peers; young adults may struggle when they leave home to live independently.

The result can be few significant relationships outside the family and a lack of autonomy and financial independence from their family of origin. In addition, some individuals with OCD try to impose rules and prohibitions on family members because of their disorder (e.g., no one in the family can have visitors to the house for fear of contamination), and this can lead to family dysfunction.

Differential Diagnosis

Anxiety disorders. Recurrent thoughts, avoidant behaviors, and repetitive requests for reassurance can also occur in anxiety disorders. However, the recurrent thoughts that are present in generalized anxiety disorder (i.e., worries) are usually about real-life concerns, whereas the obsessions of OCD usually do not involve real-life concerns and can include content that is odd, irrational, or of a seemingly magical nature; moreover, compulsions are often present and usually linked to the obsessions. Like individuals with OCD, individuals with specific phobia can have a fear reaction to specific objects or situations; however, in specific phobia the feared object is usually much more circumscribed, and rituals are not present. In social anxiety disorder (social phobia), the feared objects or situations are limited to social interactions, and avoidance or reassurance seeking is focused on reducing this social fear.

Major depressive disorder. OCD can be distinguished from the rumination of major depressive disorder, in which thoughts are usually mood-congruent and not necessarily experienced as intrusive or distressing; moreover, ruminations are not linked to compulsions, as is typical in OCD.

Other obsessive-compulsive and related disorders. In body dysmorphic disorder, the obsessions and compulsions are limited to concerns about physical appearance; and in trichotillomania (hair-pulling disorder), the compulsive behavior is limited to hair pulling in the absence of obsessions. Hoarding disorder symptoms focus exclusively on the persistent difficulty discarding or parting with possessions, marked distress associated with discarding items, and excessive accumulation of objects. However, if an individual has obsessions that are typical of OCD (e.g., concerns about incompleteness or harm), and these obsessions lead to compulsive hoarding behaviors (e.g., acquiring all objects in a set to attain a sense of completeness or not discarding old newspapers because they may contain information that could prevent harm), a diagnosis of OCD should be given instead.

Eating disorders. OCD can be distinguished from anorexia nervosa in that in OCD the obsessions and compulsions are not limited to concerns about weight and food.

Tics (in tic disorder) and stereotyped movements. A *tic* is a sudden, rapid, recurrent, nonrhythmic motor movement or vocalization (e.g., eye blinking, throat clearing). A *stereotyped movement* is a repetitive, seemingly driven, nonfunctional motor behavior (e.g., head banging, body rocking, self-biting). Tics and stereotyped movements are typically less complex than compulsions and are not aimed at neutralizing obsessions. However, distinguishing between complex tics and compulsions can be difficult. Whereas compulsions are usually preceded by obsessions, tics are often preceded by premonitory sensory urges. Some individuals have symptoms of both OCD and a tic disorder, in which case both diagnoses may be warranted.

Psychotic disorders. Some individuals with OCD have poor insight or even delusional OCD beliefs. However, they have obsessions and compulsions (distinguishing their condition from delusional disorder) and do not have other features of schizophrenia or schizoaffective disorder (e.g., hallucinations or formal thought disorder).

Other compulsive-like behaviors. Certain behaviors are sometimes described as "compulsive," including sexual behavior (in the case of paraphilias), gambling (i.e., gambling

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.

Deveiopment 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-Reiated Dlagnostic 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.

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 (F63.2)**

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.

Cuiture-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 Trichotiiiomania (Hair-Puliing 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.

Neurodevelopmental disorders. In neurodevelopmental disorders, hair pulling may meet the definition of stereotypies (e.g., in stereotypic movement disorder). Tics (in tic disorders) rarely lead to hair pulling.

Psychotic disorder. Individuals with a psychotic disorder may remove hair in response to a delusion or hallucination. Trichotillomania is not diagnosed in such cases.

Another medical condition. Trichotillomania is not diagnosed if the hair pulling or hair loss is attributable to another medical condition (e.g., inflammation of the skin or other dermatological conditions). Other causes of scarring alopecia (e.g., alopecia areata, androgenic alopecia, telogen effluvium) or nonscarring alopecia (e.g., chronic discoid lupus erythematosus, lichen planopilaris, central centrifugal cicatricial alopecia, pseudopelade, folliculitis decalvans, dissecting folliculitis, acne keloidalis nuchae) should be considered in individuals with hair loss who deny hair pulling. Skin biopsy or dermoscopy can be used to differentiate individuals with trichotillomania from those with dermatological disorders.

Substance-related disorders. Hair-pulling symptoms may be exacerbated by certain substances—for example, stimulants—but it is less likely that substances are the primary cause of persistent hair pulling.

Comorbidity

Trichotillomania is often accompanied by other mental disorders, most commonly major depressive disorder and excoriation (skin-picking) disorder. Repetitive body-focused symptoms other than hair pulling or skin picking (e.g. nail biting) occur in the majority of individuals with trichotillomania and may deserve an additional diagnosis of other specified obsessive-compulsive and related disorder (i.e., body-focused repetitive behavior disorder).

Excoriation (Skin-Picking) Disorder

Diagnostic Criteria **698.4 (L98.1)**

A. Recurrent skin picking resulting in skin lesions.
B. Repeated attempts to decrease or stop skin picking.
C. The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The skin picking is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., scabies).
E. The skin picking is not better explained by symptoms of another mental disorder (e.g., delusions or tactile hallucinations in a psychotic disorder, attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder, stereotypies in stereotypic movement disorder, or intention to harm oneself in nonsuicidal self-injury).

Diagnostic Features

The essential feature of excoriation (skin-picking) disorder is recurrent picking at one's own skin (Criterion A). The most commonly picked sites are the face, arms, and hands, but many individuals pick from multiple body sites. Individuals may pick at healthy skin, at minor skin irregularities, at lesions such as pimples or calluses, or at scabs from previous picking. Most individuals pick with their fingernails, although many use tweezers, pins, or other objects. In addition to skin picking, there may be skin rubbing, squeezing, lancing, and biting. Individuals with excoriation disorder often spend significant amounts of time on their picking behavior, sometimes several hours per day, and such skin picking may

endure for months or years. Criterion A requires that skin picking lead to skin lesions, although individuals with this disorder often attempt to conceal or camouflage such lesions (e.g., with makeup or clothing). Individuals with excoriation disorder have made repeated attempts to decrease or stop skin picking (Criterion B).

Criterion C indicates that skin picking 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 skin picking, 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 social situations.

Associated Features Supporting Diagnosis

Skin picking may be accompanied by a range of behaviors or rituals involving skin or scabs. Thus, individuals may search for a particular kind of scab to pull, and they may examine, play with, or mouth or swallow the skin after it has been pulled. Skin picking may also be preceded or accompanied by various emotional states. Skin picking may be triggered by feelings of anxiety or boredom, may be preceded by an increasing sense of tension (either immediately before picking the skin or when attempting to resist the urge to pick), and may lead to gratification, pleasure, or a sense of relief when the skin or scab has been picked. Some individuals report picking in response to a minor skin irregularity or to relieve an uncomfortable bodily sensation. Pain is not routinely reported to accompany skin picking. Some individuals engage in skin picking that is more focused (i.e., with preceding tension and subsequent relief), whereas others engage in more automatic picking (i.e., when skin picking occurs without preceding tension and without full awareness), and many have a mix of both behavioral styles. Skin picking does not usually occur in the presence of other individuals, except immediate family members. Some individuals report picking the skin of others.

Prevaience

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. This 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.

Development and Course

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.

Risk and Prognostic Factors

Genetic and physiological. Excoriation disorder is more common in individuals with obsessive-compulsive disorder (OCD) and their first-degree family members than in the general population.

Diagnostic Markers

Most individuals with excoriation disorder admit to skin picking; therefore, dermatopathological diagnosis is rarely required. However, the disorder may have characteristic features on histopathology.

Functional Consequences of Excoriation (Skin-Picking) Disorder

Excoriation disorder is associated with distress as well as with social and occupational impairment. The majority of individuals with this condition spend at least 1 hour per day picking, thinking about picking, and resisting urges to pick. Many individuals report avoiding social or entertainment events as well as going out in public. A majority of individuals with the disorder also report experiencing work interference from skin picking on at least a daily or weekly basis. A significant proportion of students with excoriation disorder report having missed school, having experienced difficulties managing responsibilities at school, or having had difficulties studying because of skin picking. Medical complications of skin picking include tissue damage, scarring, and infection and can be life-threatening. Rarely, synovitis of the wrists due to chronic picking has been reported. Skin picking often results in significant tissue damage and scarring. It frequently requires antibiotic treatment for infection, and on occasion it may require surgery.

Differential Diagnosis

Psychotic disorder. Skin picking may occur in response to a delusion (i.e., parasitosis) or tactile hallucination (i.e., formication) in a psychotic disorder. In such cases, excoriation disorder should not be diagnosed.

Other obsessive-compulsive and related disorders. Excessive washing compulsions in response to contamination obsessions in individuals with OCD may lead to skin lesions, and skin picking may occur in individuals with body dysmorphic disorder who pick their skin solely because of appearance concerns; in such cases, excoriation disorder should not be diagnosed. The description of body-focused repetitive behavior disorder in other specified obsessive-compulsive and related disorder excludes individuals whose symptoms meet diagnostic criteria for excoriation disorder.

Neurodevelopmental disorders. While stereotypic movement disorder may be characterized by repetitive self-injurious behavior, onset is in the early developmental period. For example, individuals with the neurogenetic condition Prader-Willi syndrome may have early onset of skin picking, and their symptoms may meet criteria for stereotypic movement disorder. While tics in individuals with Tourette's disorder may lead to self-injury, the behavior is not tic-like in excoriation disorder.

Somatic symptom and related disorders. Excoriation disorder is not diagnosed if the skin lesion is primarily attributable to deceptive behaviors in factitious disorder.

Other disorders. Excoriation disorder is not diagnosed if the skin picking is primarily attributable to the intention to harm oneself that is characteristic of nonsuicidal self-injury.

Other medical conditions. Excoriation disorder is not diagnosed if the skin picking is primarily attributable to another medical condition. For example, scabies is a dermatological condition invariably associated with severe itching and scratching. However, excoriation disorder may be precipitated or exacerbated by an underlying dermatological condition. For example, acne may lead to some scratching and picking, which may also be associated with comorbid excoriation disorder. The differentiation between these two clinical situations (acne with some scratching and picking vs. acne with comorbid excoriation disorder) requires an assessment of the extent to which the individual's skin picking has become independent of the underlying dermatological condition.

Substance/medication-induced disorders. Skin-picking symptoms may also be induced by certain substances (e.g., cocaine), in which case excoriation disorder should not be diagnosed. If such skin picking is clinically significant, then a diagnosis of substance/medication-induced obsessive-compulsive and related disorder should be considered.

Comorbidity

Excoriation disorder is often accompanied by other mental disorders. Such disorders include OCD and trichotillomania (hair-pulling disorder), as well as major depressive disorder. Repetitive body-focused symptoms other than skin picking and hair pulling (e.g., nail biting) occur in many individuals with excoriation disorder and may deserve an additional diagnosis of other specified obsessive-compulsive and related disorder (i.e., body-focused repetitive behavior disorder).

Substance/Medication-Induced Obsessive-Compulsive and Related Disorder

Diagnostic Criteria

A. Obsessions, compulsions, skin picking, hair pulling, other body-focused repetitive behaviors, or other symptoms characteristic of the obsessive-compulsive and related disorders predominate in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

   1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
   2. The involved substance/medication is capable of producing the symptoms in Criterion A.

C. The disturbance is not better explained by an obsessive-compulsive and related disorder that is not substance/medication-induced. Such evidence of an independent obsessive-compulsive and related disorder could include the following:

   The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced obsessive-compulsive and related disorder (e.g., a history of recurrent non-substance/medication-related episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

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

Note: This diagnosis should be made in addition to a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and are sufficiently severe to warrant clinical attention.

Coding note: The ICD-9-CM and ICD-10-CM codes for the [specific substance/medication]-induced obsessive-compulsive and related disorders are indicated in the table below. Note that the ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. If a mild substance use disorder is comorbid with the substance-induced obsessive-compulsive and related disorder, the 4th position character is "1," and the clinician should record "mild [substance] use disorder" before the substance-induced obsessive-compulsive and related disorder (e.g., "mild cocaine use disorder with cocaine-induced obsessive-compulsive and related disorder"). If a moderate or severe substance use disorder is comorbid with the substance-induced obsessive-compulsive and related disorder, the 4th position character is "2," and the clinician should record "moderate [substance] use disorder" or "severe [substance] use disorder," depending on the severity of the comorbid substance use disorder. If there is no comorbid

substance use disorder (e.g., after a one-time heavy use of the substance), then the 4th position character is "9," and the clinician should record only the substance-induced obsessive-compulsive and related disorder.

		ICD-10-CM		
	ICD-9-CM	With use disorder, mild	With use disorder, moderate or severe	Without use disorder
Amphetamine (or other stimulant)	292.89	F15.188	F15.288	F15.988
Cocaine	292.89	F14.188	F14.288	F14.988
Other (or unknown) substance	292.89	F19.188	F19.288	F19.988

Specify if (see Table 1 in the chapter "Substance-Related and Addictive Disorders" for diagnoses associated with substance class):

With onset during intoxication: If the criteria are met for intoxication with the substance and the symptoms develop during intoxication.

With onset during withdrawal: If criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal.

With onset after medication use: Symptoms may appear either at initiation of medication or after a modification or change in use.

Recording Procedures

ICD-9-CM. The name of the substance/medication-induced obsessive-compulsive and related disorder begins with the specific substance (e.g., cocaine) that is presumed to be causing the obsessive-compulsive and related symptoms. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class. For substances that do not fit into any of the classes, the code for "other substance" should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the category "unknown substance" should be used.

The name of the disorder is followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal, with onset after medication use). Unlike the recording procedures for ICD-10-CM, which combine the substance-induced disorder and substance use disorder into a single code, for ICD-9-CM a separate diagnostic code is given for the substance use disorder. For example, in the case of repetitive behaviors occurring during intoxication in a man with a severe cocaine use disorder, the diagnosis is 292.89 cocaine-induced obsessive-compulsive and related disorder, with onset during intoxication. An additional diagnosis of 304.20 severe cocaine use disorder is also given. When more than one substance is judged to play a significant role in the development of the obsessive-compulsive and related disorder, each should be listed separately.

ICD-10-CM. The name of the substance/medication-induced obsessive-compulsive and related disorder begins with the specific substance (e.g., cocaine) that is presumed to be causing the obsessive-compulsive and related symptoms. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class and presence or absence of a comorbid substance use disorder. For substances that do not fit into any of the classes, the code for "other substance" with no comorbid substance use should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the category "unknown substance" with no comorbid substance use should be used.

When recording the name of the disorder, the comorbid substance use disorder (if any) is listed first, followed by the word "with," followed by the name of the substance-induced obsessive-compulsive and related disorder, followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal, with onset after medication use). For example, in the case of repetitive behaviors occurring during intoxication in a man with a severe cocaine use disorder, the diagnosis is F14.288 severe cocaine use disorder with cocaine-induced obsessive-compulsive and related disorder, with onset during intoxication. A separate diagnosis of the comorbid severe cocaine use disorder is not given. If the substance-induced obsessive-compulsive and related disorder occurs without a comorbid substance use disorder (e.g., after a one-time heavy use of the substance), no accompanying substance use disorder is noted (e.g., F15.988 amphetamine-induced obsessive-compulsive and related disorder, with onset during intoxication). When more than one substance is judged to play a significant role in the development of the obsessive-compulsive and related disorder, each should be listed separately.

Diagnostic Features

The essential features of substance/medication-induced obsessive-compulsive and related disorder are prominent symptoms of an obsessive-compulsive and related disorder (Criterion A) that are judged to be attributable to the effects of a substance (e.g., drug of abuse, medication). The obsessive-compulsive and related disorder symptoms must have developed during or soon after substance intoxication or withdrawal or after exposure to a medication or toxin, and the substance/medication must be capable of producing the symptoms (Criterion B). Substance/medication-induced obsessive-compulsive and related disorder due to a prescribed treatment for a mental disorder or general medical condition must have its onset while the individual is receiving the medication. Once the treatment is discontinued, the obsessive-compulsive and related disorder symptoms will usually improve or remit within days to several weeks to 1 month (depending on the half-life of the substance/medication). The diagnosis of substance/medication-induced obsessive-compulsive and related disorder should not be given if onset of the obsessive-compulsive and related disorder symptoms precedes the substance intoxication or medication use, or if the symptoms persist for a substantial period of time, usually longer than 1 month, from the time of severe intoxication or withdrawal. If the obsessive-compulsive and related disorder symptoms persist for a substantial period of time, other causes for the symptoms should be considered. The substance/medication-induced obsessive-compulsive and related disorder diagnosis should be made in addition to a diagnosis of substance intoxication only when the symptoms in Criterion A predominate in the clinical picture and are sufficiently severe to warrant independent clinical attention

Associated Features Supporting Diagnosis

Obsessions, compulsions, hair pulling, skin picking, or other body-focused repetitive behaviors can occur in association with intoxication with the following classes of substances: stimulants (including cocaine) and other (or unknown) substances. Heavy metals and toxins may also cause obsessive-compulsive and related disorder symptoms. Laboratory assessments (e.g., urine toxicology) may be useful to measure substance intoxication as part of an assessment for obsessive-compulsive and related disorders.

Prevalence

In the general population, the very limited data that are available indicate that substance-induced obsessive-compulsive and related disorder is very rare.

Differential Diagnosis

Substance intoxication. Obsessive-compulsive and related disorder symptoms may occur in substance intoxication. The diagnosis of the substance-specific intoxication will usu-

ally suffice to categorize the symptom presentation. A diagnosis of an obsessive-compulsive and related disorder should be made in addition to substance intoxication when the symptoms are judged to be in excess of those usually associated with intoxication and are sufficiently severe to warrant independent clinical attention.

Obsessive-compulsive and related disorder (i.e., not induced by a substance). Substance/medication-induced obsessive-compulsive and related disorder is judged to be etiologically related to the substance/medication. Substance/medication-induced obsessive-compulsive and related disorder is distinguished from a primary obsessive-compulsive and related disorder by considering the onset, course, and other factors with respect to substances/medications. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings for use or intoxication. Substance/medication-induced obsessive-compulsive and related disorder arises only in association with intoxication, whereas a primary obsessive-compulsive and related disorder may precede the onset of substance/medication use. The presence of features that are atypical of a primary obsessive-compulsive and related disorder, such as atypical age at onset of symptoms, may suggest a substance-induced etiology. A primary obsessive-compulsive and related disorder diagnosis is warranted if the symptoms persist for a substantial period of time (about 1 month or longer) after the end of the substance intoxication or the individual has a history of an obsessive-compulsive and related disorder.

Obsessive-compulsive and related disorder due to another medical condition. If the obsessive-compulsive and related disorder symptoms are attributable to another medical condition (i.e., rather than to the medication taken for the other medical condition), obsessive-compulsive and related disorder due to another medical condition should be diagnosed. The history often provides the basis for judgment. At times, a change in the treatment for the other medical condition (e.g., medication substitution or discontinuation) may be needed to determine whether or not the medication is the causative agent (in which case the symptoms may be better explained by substance/medication-induced obsessive-compulsive and related disorder). If the disturbance is attributable to both another medical condition and substance use, both diagnoses (i.e., obsessive-compulsive and related disorder due to another medical condition and substance/medication-induced obsessive-compulsive and related disorder) may be given. When there is insufficient evidence to determine whether the symptoms are attributable to either a substance/medication or another medical condition or are primary (i.e., attributable to neither a substance/medication nor another medical condition), a diagnosis of other specified or unspecified obsessive-compulsive and related disorder would be indicated.

Delirium. If obsessive-compulsive and related disorder symptoms occur exclusively during the course of delirium, they are considered to be an associated feature of the delirium and are not diagnosed separately.

Obsessive-Compulsive and Related Disorder Due to Another Medical Condition

Diagnostic Criteria **294.8 (F06.8)**

A. Obsessions, compulsions, preoccupations with appearance, hoarding, skin picking, hair pulling, other body-focused repetitive behaviors, or other symptoms characteristic of obsessive-compulsive and related disorder predominate in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.

C. The disturbance is not better explained by another mental disorder.

D. The disturbance does not occur exclusively during the course of a delirium.
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With obsessive-compulsive disorder–like symptoms: If obsessive-compulsive disorder–like symptoms predominate in the clinical presentation.

With appearance preoccupations: If preoccupation with perceived appearance defects or flaws predominates in the clinical presentation.

With hoarding symptoms: If hoarding predominates in the clinical presentation.

With hair-pulling symptoms: If hair pulling predominates in the clinical presentation.

With skin-picking symptoms: If skin picking predominates in the clinical presentation.

Coding note: Include the name of the other medical condition in the name of the mental disorder (e.g., 294.8 [F06.8] obsessive-compulsive and related disorder due to cerebral infarction). The other medical condition should be coded and listed separately immediately before the obsessive-compulsive and related disorder due to the medical condition (e.g., 438.89 [I69.398] cerebral infarction; 294.8 [F06.8] obsessive-compulsive and related disorder due to cerebral infarction).

Diagnostic Features

The essential feature of obsessive-compulsive and related disorder due to another medical condition is clinically significant obsessive-compulsive and related symptoms that are judged to be best explained as the direct pathophysiological consequence of another medical condition. Symptoms can include prominent obsessions, compulsions, preoccupations with appearance, hoarding, hair pulling, skin picking, or other body-focused repetitive behaviors (Criterion A). The judgment that the symptoms are best explained by the associated medical condition must be based on evidence from the history, physical examination, or laboratory findings (Criterion B). Additionally, it must be judged that the symptoms are not better explained by another mental disorder (Criterion C). The diagnosis is not made if the obsessive-compulsive and related symptoms occur only during the course of a delirium (Criterion D). The obsessive-compulsive and related symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion E).

In determining whether the obsessive-compulsive and related symptoms are attributable to another medical condition, a relevant medical condition must be present. Furthermore, it must be established that obsessive-compulsive and related symptoms can be etiologically related to the medical condition through a pathophysiological mechanism and that this best explains the symptoms in the individual. Although there are no infallible guidelines for determining whether the relationship between the obsessive-compulsive and related symptoms and the medical condition is etiological, considerations that may provide some guidance in making this diagnosis include the presence of a clear temporal association between the onset, exacerbation, or remission of the medical condition and the obsessive-compulsive and related symptoms; the presence of features that are atypical of a primary obsessive-compulsive and related disorder (e.g., atypical age at onset or course); and evidence in the literature that a known physiological mechanism (e.g., striatal damage) causes obsessive-compulsive and related symptoms. In addition, the disturbance cannot be better explained by a primary obsessive-compulsive and related disorder, a substance/medication-induced obsessive-compulsive and related disorder, or another mental disorder.

There is some controversy about whether obsessive-compulsive and related disorders can be attributed to Group A streptococcal infection. Sydenham's chorea is the neurolog-

ical manifestation of rheumatic fever, which is in turn due to Group A streptococcal infection. Sydenham's chorea is characterized by a combination of motor and nonmotor features. Nonmotor features include obsessions, compulsions, attention deficit, and emotional lability. Although individuals with Sydenham's chorea may present with nonneuropsychiatric features of acute rheumatic fever, such as carditis and arthritis, they may present with obsessive-compulsive disorder–like symptoms; such individuals should be diagnosed with obsessive-compulsive and related disorder due to another medical condition.

Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) has been identified as another post-infectious autoimmune disorder characterized by the sudden onset of obsessions, compulsions, and/or tics accompanied by a variety of acute neuropsychiatric symptoms in the absence of chorea, carditis, or arthritis, after Group A streptococcal infection. Although there is a body of evidence that supports the existence of PANDAS, it remains a controversial diagnosis. Given this ongoing controversy, the description of PANDAS has been modified to eliminate etiological factors and to designate an expanded clinical entity: pediatric acute-onset neuropsychiatric syndrome (PANS) or idiopathic childhood acute neuropsychiatric symptoms (CANS), which deserves further study.

Associated Features Supporting Diagnosis

A number of other medical disorders are known to include obsessive-compulsive and related symptoms as a manifestation. Examples include disorders leading to striatal damage, such as cerebral infarction.

Development and Course

The development and course of obsessive-compulsive and related disorder due to another medical condition generally follows the course of the underlying illness.

Diagnostic Markers

Laboratory assessments and/or medical examinations are necessary to confirm the diagnosis of another medical condition.

Differential Diagnosis

Delirium. A separate diagnosis of obsessive-compulsive and related disorder due to another medical condition is not given if the disturbance occurs exclusively during the course of a delirium. However, a diagnosis of obsessive-compulsive and related disorder due to another medical condition may be given in addition to a diagnosis of major neurocognitive disorder (dementia) if the etiology of the obsessive-compulsive symptoms is judged to be a physiological consequence of the pathological process causing the dementia and if obsessive-compulsive symptoms are a prominent part of the clinical presentation.

Mixed presentation of symptoms (e.g., mood and obsessive-compulsive and related disorder symptoms). If the presentation includes a mix of different types of symptoms, the specific mental disorder due to another medical condition depends on which symptoms predominate in the clinical picture.

Substance/medication-induced obsessive-compulsive and related disorders. If there is evidence of recent or prolonged substance use (including medications with psychoactive effects), withdrawal from a substance, or exposure to a toxin, a substance/medication-induced obsessive-compulsive and related disorder should be considered. When a substance/medication-induced obsessive-compulsive and related disorder is being diagnosed in relation to drugs of abuse, it may be useful to obtain a urine or blood drug screen

or other appropriate laboratory evaluation. Symptoms that occur during or shortly after (i.e., within 4 weeks of) substance intoxication or withdrawal or after medication use may be especially indicative of a substance/medication-induced obsessive-compulsive and related disorder, depending on the type, duration, or amount of the substance used.

Obsessive-compulsive and related disorders (primary). Obsessive-compulsive and related disorder due to another medical condition should be distinguished from a primary obsessive-compulsive and related disorder. In primary mental disorders, no specific and direct causative physiological mechanisms associated with a medical condition can be demonstrated. Late age at onset or atypical symptoms suggest the need for a thorough assessment to rule out the diagnosis of obsessive-compulsive and related disorder due to another medical condition.

Illness anxiety disorder. Illness anxiety disorder is characterized by a preoccupation with having or acquiring a serious illness. In the case of illness anxiety disorder, individuals may or may not have diagnosed medical conditions.

Associated feature of another mental disorder. Obsessive-compulsive and related symptoms may be an associated feature of another mental disorder (e.g., schizophrenia, anorexia nervosa).

Other specified obsessive-compulsive and related disorder or unspecified obsessive-compulsive and related disorder. These diagnoses are given if it is unclear whether the obsessive-compulsive and related symptoms are primary, substance-induced, or due to another medical condition.

Other Specified Obsessive-Compulsive and Related Disorder

300.3 (F42)

This category applies to presentations in which symptoms characteristic of an obsessive-compulsive and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the obsessive-compulsive and related disorders diagnostic class. The other specified obsessive-compulsive and related disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific obsessive-compulsive and related disorder. This is done by recording "other specified obsessive-compulsive and related disorder" followed by the specific reason (e.g., "body-focused repetitive behavior disorder").

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Body dysmorphic–like disorder with actual flaws:** This is similar to body dysmorphic disorder except that the defects or flaws in physical appearance are clearly observable by others (i.e., they are more noticeable than "slight"). In such cases, the preoccupation with these flaws is clearly excessive and causes significant impairment or distress.
2. **Body dysmorphic–like disorder without repetitive behaviors:** Presentations that meet body dysmorphic disorder except that the individual has not performed repetitive behaviors or mental acts in response to the appearance concerns.
3. **Body-focused repetitive behavior disorder:** This is characterized by recurrent body-focused repetitive behaviors (e.g., nail biting, lip biting, cheek chewing) and repeated attempts to decrease or stop the behaviors. These symptoms cause clinically significant

distress or impairment in social, occupational, or other important areas of functioning and are not better explained by trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder, stereotypic movement disorder, or nonsuicidal self-injury.

4. **Obsessional jealousy:** This is characterized by nondelusional preoccupation with a partner's perceived infidelity. The preoccupations may lead to repetitive behaviors or mental acts in response to the infidelity concerns; they cause clinically significant distress or impairment in social, occupational, or other important areas of functioning; and they are not better explained by another mental disorder such as delusional disorder, jealous type, or paranoid personality disorder.
5. ***Shubo-kyofu:*** A variant of *taijin kyofusho* (see "Glossary of Cultural Concepts of Distress" in the Appendix) that is similar to body dysmorphic disorder and is characterized by excessive fear of having a bodily deformity.
6. ***Koro:*** Related to *dhat syndrome* (see "Glossary of Cultural Concepts of Distress" in the Appendix), an episode of sudden and intense anxiety that the penis (or the vulva and nipples in females) will recede into the body, possibly leading to death.
7. ***Jikoshu-kyofu:*** A variant of *taijin kyofusho* (see "Glossary of Cultural Concepts of Distress" in the Appendix) characterized by fear of having an offensive body odor (also termed *olfactory reference syndrome*).

Unspecified Obsessive-Compulsive and Related Disorder

300.3 (F42)

This category applies to presentations in which symptoms characteristic of an obsessive-compulsive and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the obsessive-compulsive and related disorders diagnostic class. The unspecified obsessive-compulsive and related disorder category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific obsessive-compulsive and related disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

Trauma- and Stressor-Related Disorders

Trauma- and stressor-related disorders include disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion. These include reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders. Placement of this chapter reflects the close relationship between these diagnoses and disorders in the surrounding chapters on anxiety disorders, obsessive-compulsive and related disorders, and dissociative disorders.

Psychological distress following exposure to a traumatic or stressful event is quite variable. In some cases, symptoms can be well understood within an anxiety- or fear-based context. It is clear, however, that many individuals who have been exposed to a traumatic or stressful event exhibit a phenotype in which, rather than anxiety- or fear-based symptoms, the most prominent clinical characteristics are anhedonic and dysphoric symptoms, externalizing angry and aggressive symptoms, or dissociative symptoms. Because of these variable expressions of clinical distress following exposure to catastrophic or aversive events, the aforementioned disorders have been grouped under a separate category: *trauma- and stressor-related disorders.* Furthermore, it is not uncommon for the clinical picture to include some combination of the above symptoms (with or without anxiety- or fear-based symptoms). Such a heterogeneous picture has long been recognized in adjustment disorders, as well. Social neglect—that is, the absence of adequate caregiving during childhood—is a diagnostic requirement of both reactive attachment disorder and disinhibited social engagement disorder. Although the two disorders share a common etiology, the former is expressed as an internalizing disorder with depressive symptoms and withdrawn behavior, while the latter is marked by disinhibition and externalizing behavior.

Reactive Attachment Disorder

Diagnostic Criteria **313.89 (F94.1)**

A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:
   1. The child rarely or minimally seeks comfort when distressed.
   2. The child rarely or minimally responds to comfort when distressed.

B. A persistent social and emotional disturbance characterized by at least two of the following:
   1. Minimal social and emotional responsiveness to others.
   2. Limited positive affect.
   3. Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.

C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
   1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.

2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).
E. The criteria are not met for autism spectrum disorder.
F. The disturbance is evident before age 5 years.
G. The child has a developmental age of at least 9 months.

Specify if:

Persistent: The disorder has been present for more than 12 months.

Specify current severity:

Reactive attachment disorder is specified as **severe** when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

Diagnostic Features

Reactive attachment disorder of infancy or early childhood is characterized by a pattern of markedly disturbed and developmentally inappropriate attachment behaviors, in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protection, and nurturance. The essential feature is absent or grossly underdeveloped attachment between the child and putative caregiving adults. Children with reactive attachment disorder are believed to have the capacity to form selective attachments. However, because of limited opportunities during early development, they fail to show the behavioral manifestations of selective attachments. That is, when distressed, they show no consistent effort to obtain comfort, support, nurturance, or protection from caregivers. Furthermore, when distressed, children with this disorder do not respond more than minimally to comforting efforts of caregivers. Thus, the disorder is associated with the absence of expected comfort seeking and response to comforting behaviors. As such, children with reactive attachment disorder show diminished or absent expression of positive emotions during routine interactions with caregivers. In addition, their emotion regulation capacity is compromised, and they display episodes of negative emotions of fear, sadness, or irritability that are not readily explained. A diagnosis of reactive attachment disorder should not be made in children who are developmentally unable to form selective attachments. For this reason, the child must have a developmental age of at least 9 months.

Associated Features Supporting Diagnosis

Because of the shared etiological association with social neglect, reactive attachment disorder often co-occurs with developmental delays, especially in delays in cognition and language. Other associated features include stereotypies and other signs of severe neglect (e.g., malnutrition or signs of poor care).

Prevaience

The prevalence of reactive attachment disorder is unknown, but the disorder is seen relatively rarely in clinical settings. The disorder has been found in young children exposed to severe neglect before being placed in foster care or raised in institutions. However, even in populations of severely neglected children, the disorder is uncommon, occurring in less than 10% of such children.

Development and Course

Conditions of social neglect are often present in the first months of life in children diagnosed with reactive attachment disorder, even before the disorder is diagnosed. The clinical features of the disorder manifest in a similar fashion between the ages of 9 months and 5 years. That is, signs of absent-to-minimal attachment behaviors and associated emotionally aberrant behaviors are evident in children throughout this age range, although differing cognitive and motor abilities may affect how these behaviors are expressed. Without remediation and recovery through normative caregiving environments, it appears that signs of the disorder may persist, at least for several years.

It is unclear whether reactive attachment disorder occurs in older children and, if so, how it differs from its presentation in young children. Because of this, the diagnosis should be made with caution in children older than 5 years.

Risk and Prognostic Factors

Environmental. Serious social neglect is a diagnostic requirement for reactive attachment disorder and is also the only known risk factor for the disorder. However, the majority of severely neglected children do not develop the disorder. Prognosis appears to depend on the quality of the caregiving environment following serious neglect.

Cuiture-Related Diagnostic Issues

Similar attachment behaviors have been described in young children in many different cultures around the world. However, caution should be exercised in making the diagnosis of reactive attachment disorder in cultures in which attachment has not been studied.

Functional Consequences of Reactive Attachment Disorder

Reactive attachment disorder significantly impairs young children's abilities to relate interpersonally to adults or peers and is associated with functional impairment across many domains of early childhood.

Differential Diagnosis

Autism spectrum disorder. Aberrant social behaviors manifest in young children with reactive attachment disorder, but they also are key features of autism spectrum disorder. Specifically, young children with either condition can manifest dampened expression of positive emotions, cognitive and language delays, and impairments in social reciprocity. As a result, reactive attachment disorder must be differentiated from autism spectrum disorder. These two disorders can be distinguished based on differential histories of neglect and on the presence of restricted interests or ritualized behaviors, specific deficit in social communication, and selective attachment behaviors. Children with reactive attachment disorder have experienced a history of severe social neglect, although it is not always possible to obtain detailed histories about the precise nature of their experiences, especially in initial evaluations. Children with autistic spectrum disorder will only rarely have a history of social neglect. The restricted interests and repetitive behaviors characteristic of autism spectrum disorder are not a feature of reactive attachment disorder. These clinical features manifest as excessive adherence to rituals and routines; restricted, fixated interests; and unusual sensory reactions. However, it is important to note that children with either condition can exhibit stereotypic behaviors such as rocking or flapping. Children with either disorder also may exhibit a range of intellectual functioning, but only children with autis-

tic spectrum disorder exhibit selective impairments in social communicative behaviors, such as intentional communication (i.e., impairment in communication that is deliberate, goal-directed, and aimed at influencing the behavior of the recipient). Children with reactive attachment disorder show social communicative functioning comparable to their overall level of intellectual functioning. Finally, children with autistic spectrum disorder regularly show attachment behavior typical for their developmental level. In contrast, children with reactive attachment disorder do so only rarely or inconsistently, if at all.

Intellectual disability (intellectual developmental disorder). Developmental delays often accompany reactive attachment disorder, but they should not be confused with the disorder. Children with intellectual disability should exhibit social and emotional skills comparable to their cognitive skills and do not demonstrate the profound reduction in positive affect and emotion regulation difficulties evident in children with reactive attachment disorder. In addition, developmentally delayed children who have reached a cognitive age of 7–9 months should demonstrate selective attachments regardless of their chronological age. In contrast, children with reactive attachment disorder show lack of preferred attachment despite having attained a developmental age of at least 9 months.

Depressive disorders. Depression in young children is also associated with reductions in positive affect. There is limited evidence, however, to suggest that children with depressive disorders have impairments in attachment. That is, young children who have been diagnosed with depressive disorders still should seek and respond to comforting efforts by caregivers.

Comorbidity

Conditions associated with neglect, including cognitive delays, language delays, and stereotypies, often co-occur with reactive attachment disorder. Medical conditions, such as severe malnutrition, may accompany signs of the disorder. Depressive symptoms also may co-occur with reactive attachment disorder.

Disinhibited Social Engagement Disorder

Diagnostic Criteria **313.89 (F94.2)**

A. A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least two of the following:
   1. Reduced or absent reticence in approaching and interacting with unfamiliar adults.
   2. Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries).
   3. Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
   4. Willingness to go off with an unfamiliar adult with minimal or no hesitation.

B. The behaviors in Criterion A are not limited to impulsivity (as in attention-deficit/hyperactivity disorder) but include socially disinhiblted behavior.

C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
   1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
   2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
   3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).
E. The child has a developmental age of at least 9 months.

Specify if:

Persistent: The disorder has been present for more than 12 months.

Specify current severity:

Disinhibited social engagement disorder is specified as **severe** when the child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

Diagnostic Features

The essential feature of disinhibited social engagement disorder is a pattern of behavior that involves culturally inappropriate, overly familiar behavior with relative strangers (Criterion A). This overly familiar behavior violates the social boundaries of the culture. A diagnosis of disinhibited social engagement disorder should not be made before children are developmentally able to form selective attachments. For this reason, the child must have a developmental age of at least 9 months.

Associated Features Supporting Diagnosis

Because of the shared etiological association with social neglect, disinhibited social engagement disorder may co-occur with developmental delays, especially cognitive and language delays, stereotypies, and other signs of severe neglect, such as malnutrition or poor care. However, signs of the disorder often persist even after these other signs of neglect are no longer present. Therefore, it is not uncommon for children with the disorder to present with no current signs of neglect. Moreover, the condition can present in children who show no signs of disordered attachment. Thus, disinhibited social engagement disorder may be seen in children with a history of neglect who lack attachments or whose attachments to their caregivers range from disturbed to secure.

Prevalence

The prevalence of disinhibited social attachment disorder is unknown. Nevertheless, the disorder appears to be rare, occurring in a minority of children, even those who have been severely neglected and subsequently placed in foster care or raised in institutions. In such high-risk populations, the condition occurs in only about 20% of children. The condition is seen rarely in other clinical settings.

Development and Course

Conditions of social neglect are often present in the first months of life in children diagnosed with disinhibited social engagement disorder, even before the disorder is diagnosed. However, there is no evidence that neglect beginning after age 2 years is associated with manifestations of the disorder. If neglect occurs early and signs of the disorder appear, clinical features of the disorder are moderately stable over time, particularly if conditions of neglect persist. Indiscriminate social behavior and lack of reticence with unfamiliar adults in toddlerhood are accompanied by attention-seeking behaviors in preschoolers. When the disorder persists into middle childhood, clinical features manifest as verbal and physical overfamiliarity as well as inauthentic expression of emotions. These signs appear particularly apparent when the child interacts with adults. Peer relationships are most affected in adolescence, with both indiscriminate behavior and conflicts apparent. The disorder has not been described in adults.