MASSACHUSETTS GENERAL HOSPITAL
PSYCHIATRY ACADEMY

Treatment of Obsessive-Compulsive Related Disorders

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Disclosures

Neither I, nor my spouse, has a relevant financial relationship with a commercial interest to disclose.

Obsessive-Compulsive Related Disorders (OCRDs)

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

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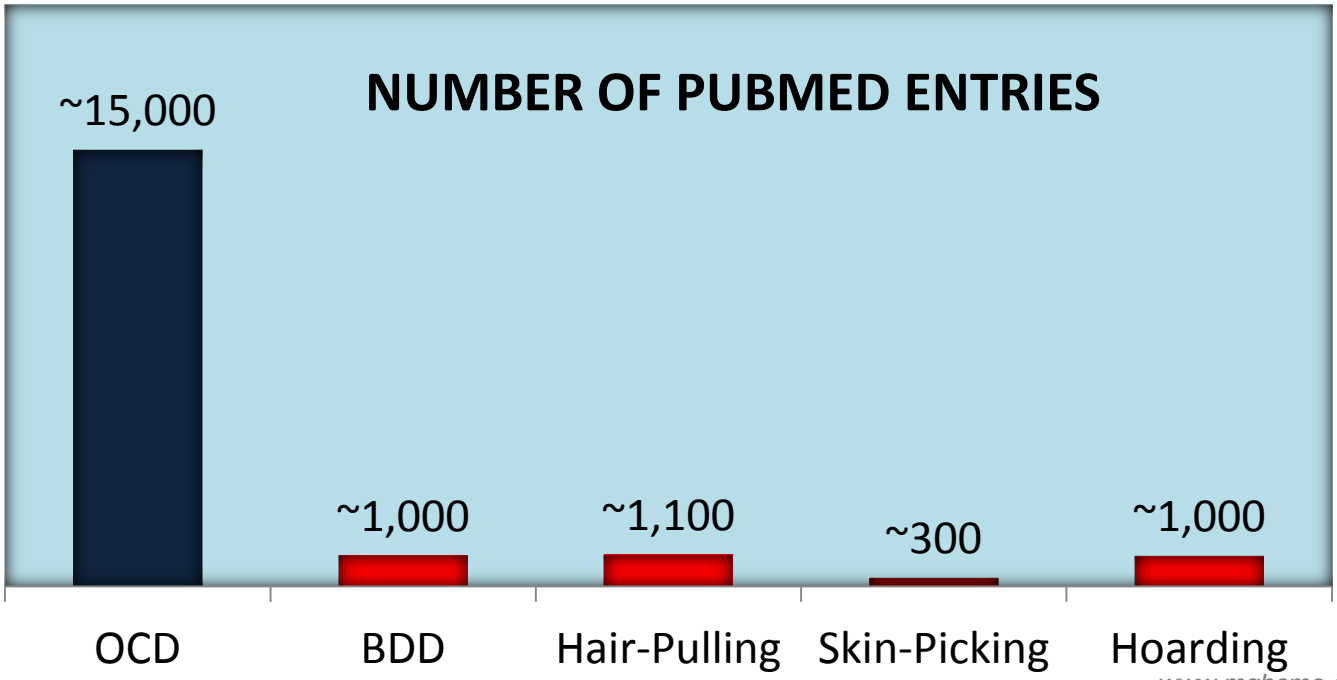
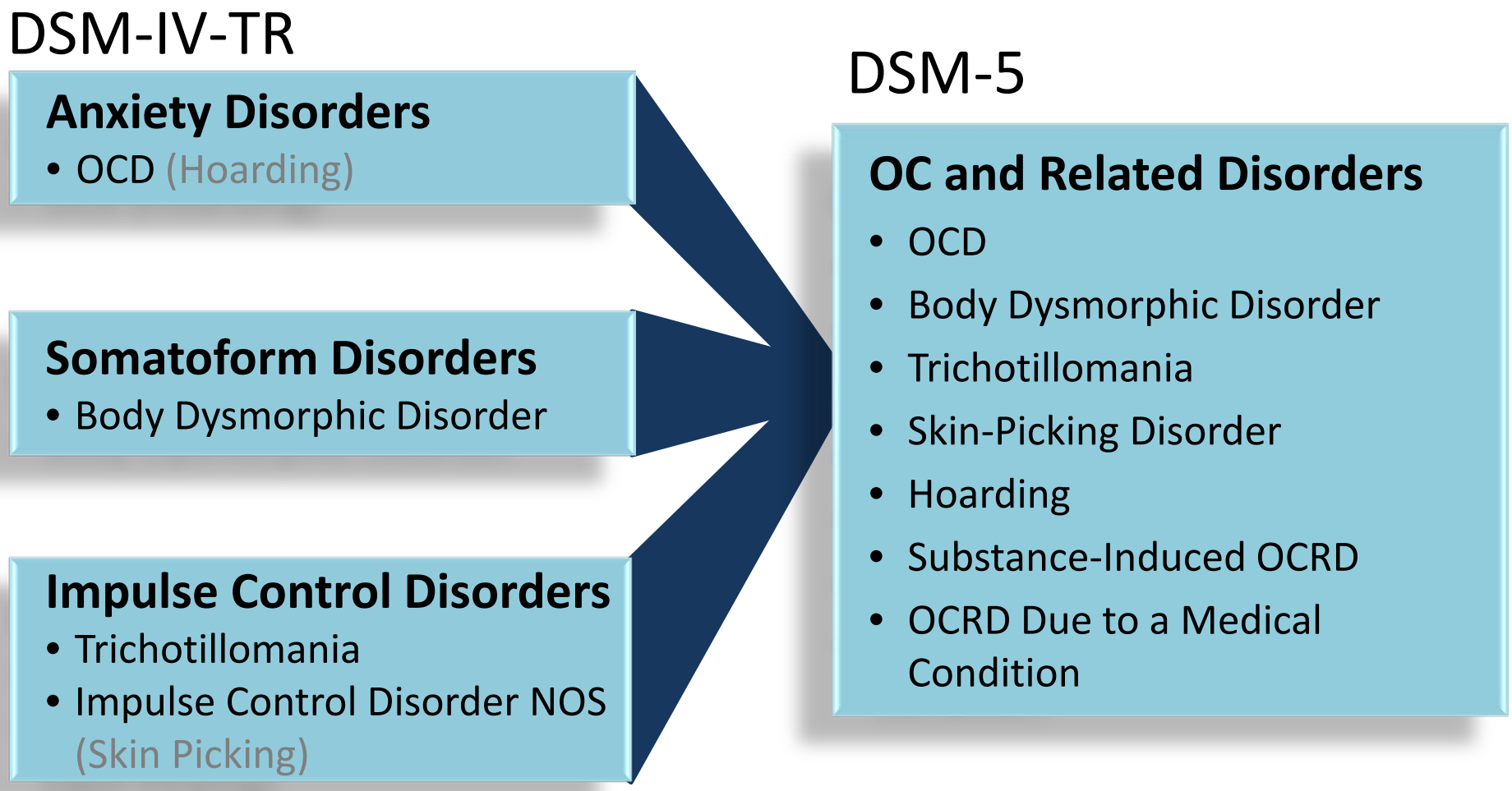


New OCD category in DSM-5



Body Dysmorphic Disorder (BDD)

Clinical features of BDD

- Distressing preoccupation with imagined or slight defect in appearance

- Usually involves skin, hair, nose, but can involve any body part
- Variable insight, may be delusional
- Pts often present to dermatologist or cosmetic surgeon

Phillips, KA. *Understanding body dysmorphic disorder : an essential guide*. 2009; Bjornsson, AS et al. *Dialogues Clin Neurosci. 2010;12*(2); Pope, CG et al. *Body Image. 2005;2*(4); Phillips, KA et al. *J Psychiatr Res. 2006;40*(2); Mancuso et al. *Compr Psychiatry*. 2010;51(2); Job_Doctor. (2011). Bigorexia. [Photo]. From https://www.flickr.com/photos/51806296@N05/5430306239/

Clinical features of BDD (cont.)

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

Phillips, KA *Understanding body dysmorphic disorder : an essential guide*. 2009; Bjornsson, AS et al. *Dialogues Clin Neurosci. 2010;12*(2); Phillips KA et al. *J Clin Psychiatry.* 2005;66(6); Didie ER, et al. *Compr Psychiatry.* 2008;49(6)

BDD is common

- 2.4% prevalence in general population (women>men)
- 12%, outpatient dermatology clinic
- 33%, pts seeking rhinoplasty

Koran, LM et al. *CNS Spectr, 2008;13*(4); Phillips, KA et al. *J Am Acad Dermatol, 2000;42*(3); Picavet, VA et al. *Plast Reconstr Surg, 2011;128*(2); Shankbone, D. (2007). Sarah Michelle Gellar. [Photo]. from http://upload.wikimedia.org/wikipedia/commons/a/a1/Sarah_Michelle_Gellar_by_David_Shankbone.jpg; Skidmore, G. (2012). Robert Pattinson. [Photo]. From http://upload.wikimedia.org/wikipedia/commons/thumb/b/b0/Robert_Pattinson_by_Gage_Skidmore.jpg/191pxRobert_Pattinson_by_Gage_Skidmore.jpg; Toglenn (2009). Hayden Panettiere. [Photo]. From https://commons.wikimedia.org/wiki/File:Hayden_Panettiere_2009_(Straighten_Crop).jpg#file; Francesco. (2011). Michael-Jackson. [Photo]. from: https://www.flickr.com/photos/kronicit/3710066082/

Diagnosis of BDD in DSM-5

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

Specify insight (good/fair, poor, or absent/delusional)

Talking to patients with BDD

- Screen all pts for BDD
- Avoid “imagined,” “deformity,” or “defect”- instead use “concern”
- Do not reassure pt that they look fine
- Assess insight, “Do you ever feel that your concern is excessive?”
- For pts with <u>good insight</u>, provide diagnosis and psychoeducation
- For pts with <u>poor insight or delusional BDD</u>:
  - Postpone diagnosis until alliance has been built
  - Postpone cosmetic procedures
  - Target medications to psychiatric sx or areas of dysfunction

Phillips, KA & Feusner, J. *Psychiatr Ann. 2010;40*(7)

Treatment of BDD

- Studies limited
- 71-76% of BDD pts seek cosmetic treatments
- Surgical/dermatologic treatment rarely improve BDD sx
- Pts with BDD much more likely to sue surgeon
- 4 surgeons murdered by pts with BDD
- Serotonin reuptake inhibitors **(SRIs)** and cognitive behavioral therapy **(CBT)** are first-line treatments

Phillips KA et al. *Psychosomatics.* 2001;42(6); Crerand CE et al. *Psychosomatics.* 2005;46(6); Sarwer DB. *Aesthet. Surg. J.* 2002;22(6); Crerand CE et al. *Plast. Reconstr. Surg.* 2006;118(70)

SRIs for BDD

- SRIs effective
  - Clomipramine, ~140 mg/d, RCT
  - Fluoxetine, ~80 mg/d, RCT
  - Escitalopram, ~30 mg/d, open-label study
  - Citalopram, ~50 mg/d, open-label study
  - Fluvoxamine, ~210-240 mg/d, open-label studies
- No direct comparative studies, SRIs thought to be equally effective
- Response delayed (10-12 weeks for full effect)
- High doses often required
- Rapid titration recommended
- Effective for patients with delusional BDD

Hollander, E et al. *Arch Gen Psychiatry. 1999;56*(11); Phillips, KA et al. *Arch Gen Psychiatry, 2002;59*(4); Phillips, KA. *Int Clin Psychopharmacol. 2006;21*(3); Phillips, KA & Najjar, FJ. *Clin Psychiatry. 2003; 64*(6); Perugi, G et al. *Int Clin Psychopharmacol.* 1996;*11*(4); Phillips, KA et al. *J Clin Psychiatry. 1998;59*(4); Phillips KA & Hollander E. *Body Image*. 2008;5(1)

Which SRI?

Drug Name	Target Dose
Escitalopram	20 mg/d
Sertraline	200 mg/d
Fluoxetine	80 mg/d
Citalopram	40 mg/d
Paroxetine	60 mg/d
Fluvoxamine	300 mg/d
Clomipramine	250 mg/d

Higher than max SRI dosing

Drug Name	Target Dose
Escitalopram	20 mg/d (up to 30 mg), EKG
Sertraline	200 mg/d (up to 300 mg/d)
Fluoxetine	80 mg/d (up to 120 mg/d)
Citalopram	40 mg/d
Paroxetine	60 mg/d
Fluvoxamine	300 mg/d
Clomipramine	250 mg/d (not recommended)

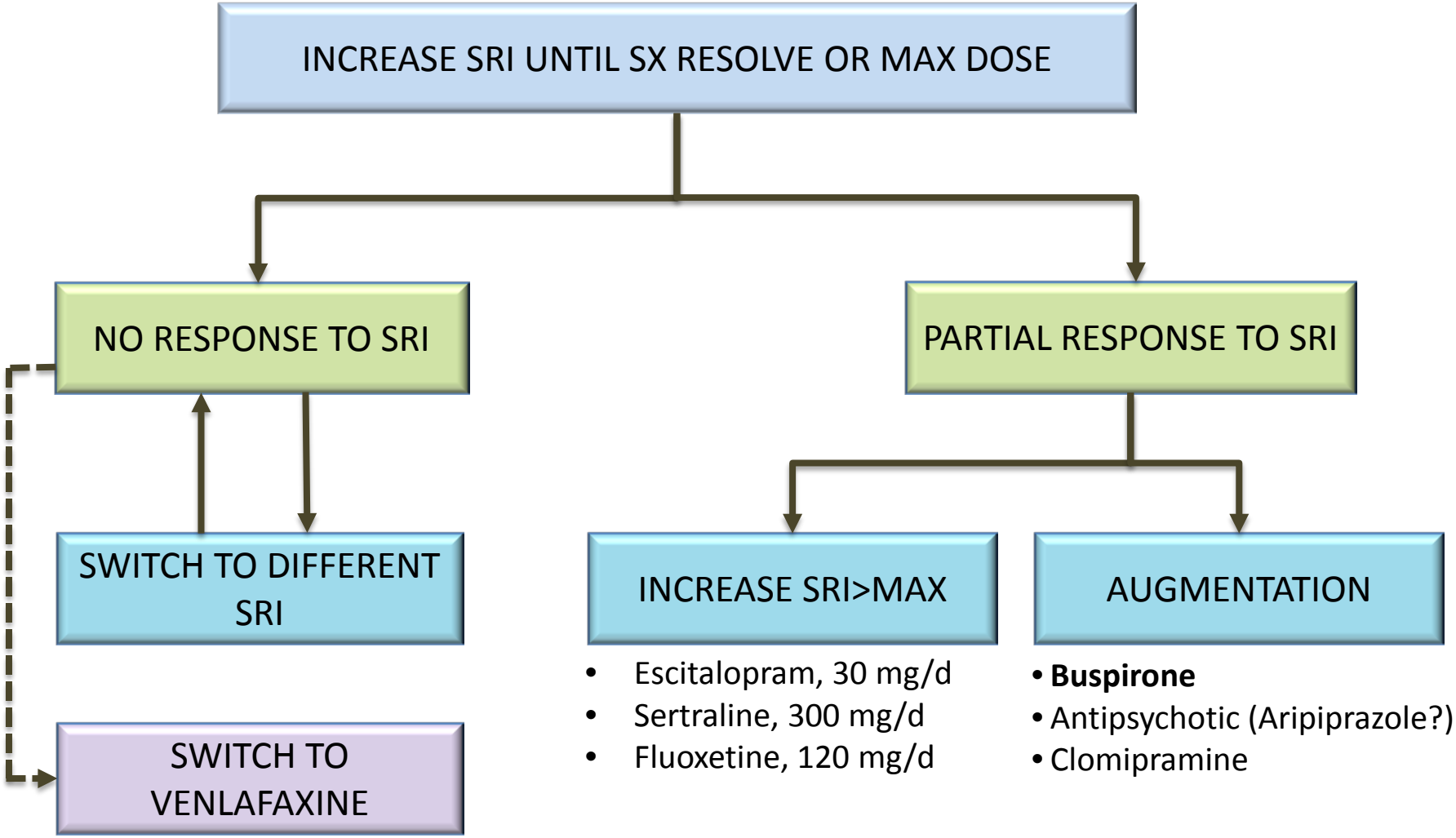
(No guidelines on above maximum dosing in BDD exist – doses in red are generally well-tolerated in my practice)

Other medications for BDD

- SRI augmentation:
  - Limited studies, very few options
  - **Buspirone** (60mg TDD) shows benefit in open-label study
  - Atypical antipsychotics-not well studied but often used
    - **Aripiprazole**, beneficial in 1 case report, 10 mg/d
    - Olanzapine, mixed case reports (2 robust, 6 no effect), ~5 mg/d
    - No studies with **risperidone** or quetiapine
    - Pimozide, not efficacious in RCT
  - **Clomipramine**, beneficial in 4 case reports, ~125 mg/d
    - Start low dose (25-50mg) and monitor EKG and level while titrating
- Other monotherapies:
  - Venlafaxine effective in small open-label study

Phillips, KA *Psychopharmacol Bull. 1996; 32*(1); Uzun O, Ozdemir B. *Clin Drug Investig*. 2010;30(10); Grant JE. *J Clin Psychiatry*. 2001;62(4); Phillips KA. *Am J Psychiatry*. 2005;162(5); Nakaaki S et al. *Psychiatry Clin Neurosci*. 2008;62(3); Phillips KA. *Am J Psychiatry.* 2005;162(2); Phillips KA et al. *J Clin Psychiatry.* 2001;62(9); Allen, A et al. *CNS Spectr, 2008;13*(2)

Suggested medication approach for BDD



Phillips, KA. *Psychiatr Ann. 2010; 40*(7)

CBT for BDD

Response (ritual) prevention

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

Cognitive restructuring

- Challenge negative thoughts related to appearance

Behavioral experiments

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

Exposures

- Face situations which might normally be avoided

Rosen, JC et al. *J Consult Clin Psychol. 1995;63*(2); Veale, D et al. Behav Res Ther, 1996;34(9); Wilhelm et al. *Cognitive and Behavioral Practice, 2010;17*; Wilhelm, S et al. *Behav Ther, 2010;42*(4); Wilhelm, S., et al. *Cognitive-behavioral therapy for body dysmorphic disorder: a treatment manual*. 2013.

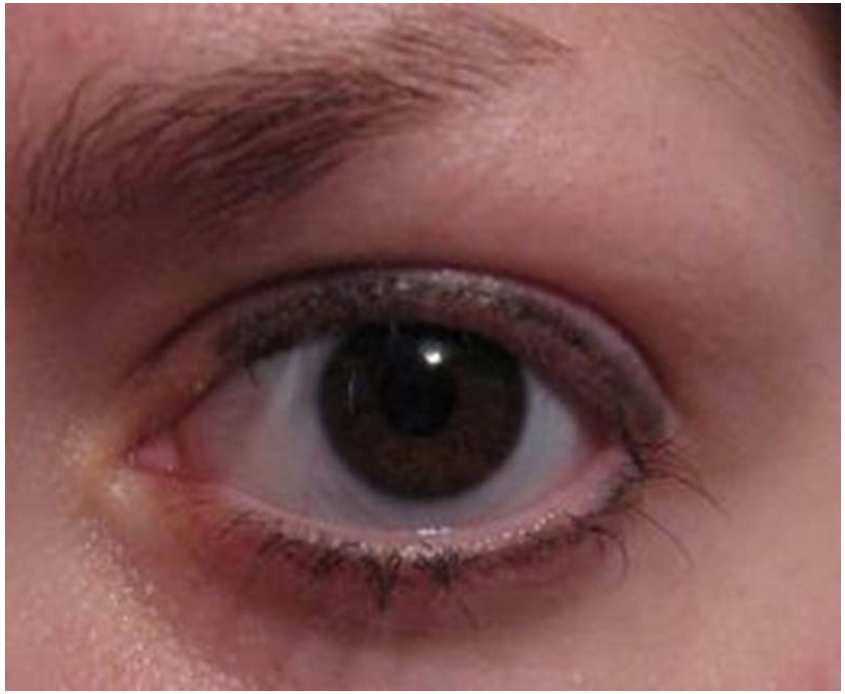
BDD resources

- ***Understanding Body Dysmorphic Disorder*** by Katharine Phillips (comprehensive overview for pts, families, and clinicians)
- ***CBT for BDD, Treatment Manual*** by Sabine Wilhelm et al (therapist guide)
- ***Feeling Good About the Way You Look*** by Sabine Wilhelm *(self-guided CBT)*
- Finding specialists
  - International OCD Foundation, www.ocfoundation.org
  - BDD Program at Rhode Island Hospital , www.rhodeislandhospital.org/psychiatry/body-image-program.html

Trichotillomania (TTM)

Clinical features of TTM

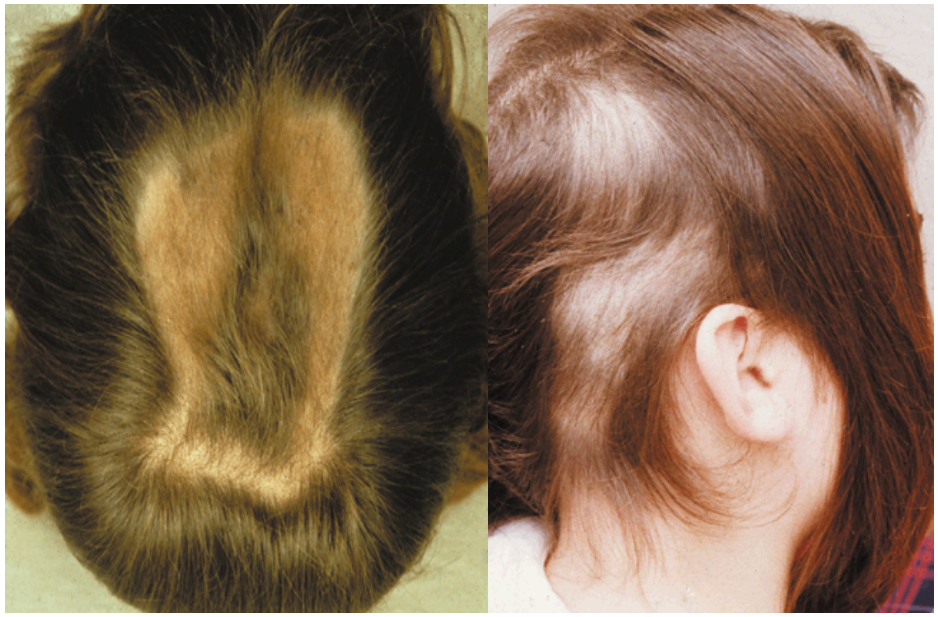
- Excessive hair-pulling resulting in hair loss
- Pulling most often on scalp and eyebrows but may be anywhere including lashes, pubic hair, and others
- Spend hours daily pulling
- ~0.6-1.2% prevalence



Grant, JE. *Trichotillomania, skin picking, and other body-focused repetitive behaviors* .1st ed. 2012; Duke, DC. *Clin Psychol Rev. 2010;30*(2); Duke, DC et al. *J Anxiety Disord.* 2009; 23(8); Trichotillomania. (2012) [Photo]. From http://profoundpuns.hubpages.com/hub/Trichotillomania-The-Secret-Hair-Pulling-Compulsion

Clinical features of TTM (cont.)

- Classic irregular hair pattern
- Hairs of varying length
- Nl hair density
- No scaling
- Shame/avoidance
- Social and occupational dysfunction



Sah, DE. *Dermatol Ther, 2008; 21*(1); Grant, JE. *Trichotillomania, skin picking, and other body-focused repetitive behaviors.* 1st ed. 2012, Copyright © 2012 John Wiley & Sons. All rights reserved. Reprinted with permission.

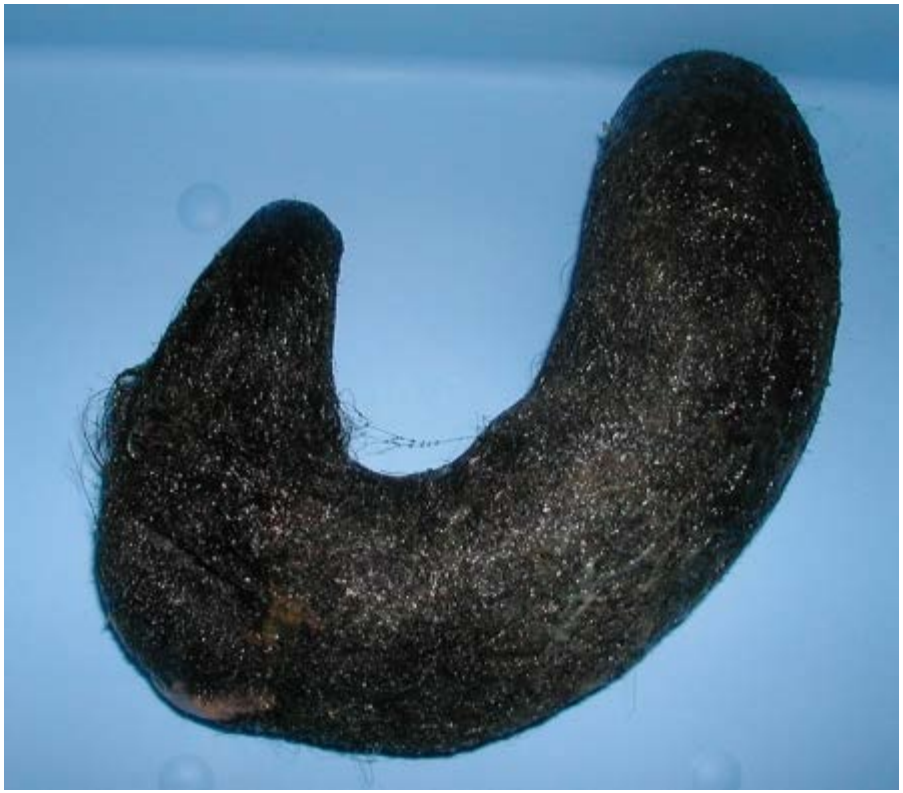
Reasons for pulling

- Triggers
  - Coping with negative emotions (depression, anger, anxiety)
  - Boredom
  - Itch or other sensory trigger
  - Hairs not feeling right
  - Aesthetics (removing gray hairs, evening eyebrows)
- Varying degrees of self-awareness
  - Conscious or focused pulling
  - Automatic pulling

Grant, JE. *Trichotillomania, skin picking, and other body-focused repetitive behaviors* 1st ed. 2012

Trichotillophagia

- Early satiety
- N/V
- Abdominal pain
- Weight loss



Trichobezoar

Diagnosis of TTM in DSM-5

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

Treatment of TTM

CBT is main treatment, medication studies limited

Habit reversal

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

Stimulus control

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

Cognitive restructuring

- Challenge maladaptive thoughts related to picking/pulling

Grant, JE. *Trichotillomania, skin picking, and other body-focused repetitive behaviors*. 1st ed. 2012; Woods DW et al. *Tic disorders, trichotillomania, and other repetitive behavior disorders : behavioral approaches to analysis and treatment*. 2001; Deckersbach, T et al. *Behav Modif, 2002;26*(3); Teng, EJ. *Behav Modif. 2006;30*(4); Woods, DW & Twohig. *Trichotillomania : an ACT-enhanced behavior therapy approach : therapist guide*. 2008; Siev, J et al. Assessment and treatment of pathological skin picking. In *Oxford Handbook of Impulse Control Disorders, 2012.*

Stimulus Control

http://store.trich.org/

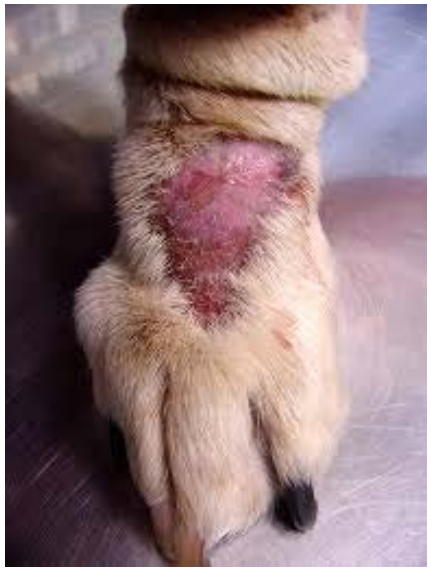
Medication treatment of TTM

- Clomipramine (CMI) was drug of choice but now questioned
  - Double blind crossover study of TTM showed CMI >> desipramine (~180mg/d)
  - In placebo-controlled RCT, CMI doesn't differentiate from placebo (~100 mg/d)
- Unclear benefit with SSRIs
  - Fluoxetine significantly reduced hair pulling in open-label study
  - Several case reports of other SSRIs reducing hair pulling
  - But no change in hair pulling in 2 RCTs of fluoxetine

Swedo SE et al. *NEJM.* 1989;321 (8); Ninan PT et al , *J Clin Psychiatry.* 2000; 61 (1); Koran LM et al, *Psychopharmacol Bull. 1992; 28 (2);* Christenson G et al, *AJP. 1991; 148(11);* Streichenwein SM & Thornby, *AJP* 1995; 152(8)

Medication treatment of TTM (cont.)

- **N-acetylcysteine (NAC)**, 1200-2400 mg/d
  - Glutamatergic modulator
  - Addiction, gambling, OCD, schizophrenia, BPAD
  - Beneficial in RCT of TTM
  - Start 600mg PO BID x 2 wks, then 1200mg PO BID, OTC



- **Naltrexone**, 50-100 mg/d
  - Opioid receptor antagonist
  - Alcohol and opioid dependence, kleptomania, gambling
  - Very effective in dogs to treat acral lick dermatitis
  - Mixed results in TTM, beneficial in open-label study in child TTM and small RCT of adult TTM, no effect in larger RCT in adult TTM
  - Monitoring: hepatotoxicity with doses >300mg/d, check LFTs 1m, 3m, 6m, yearly

- **Olanzapine**, beneficial in RCT, 10 mg/d

Grant,JE et al. *Archives of General Psychiatry.* 2009;66(7) ; De Sousa, A. *J Child Adolesc Psychopharmacol.* 2008 Feb;18(1); O'Sullivan & Christenson, *Trichotillomania,* 1999 (pg 93-124); Grant,JE et al. *J Clin Psychopharmacol*. 2014 Feb;34(1); Van Ameringen,M et al. *J Clin Psychiatry. 2010*;71(10)

Other medications for TTM

- Open-label studies
  - **Aripiprazole** (n=12), ~7.5 mg/d
  - **Topiramate**(n=14), ~160 mg/d
  - **Dronabinol** (n=14), 2.5-5 mg PO BID

- Case series
  - **Lithium**, (n=10), 900-1500mg/d
  - **Silymarin**, aka milk thistle, (n=3), 150mg PO BID

- Recommendations
  - Refer for CBT
  - No established medication guidelines exist
  - Consider trial of **NAC** (preferred)/ **naltrexone** (FH of addiction)/ **olanzapine**
  - Treat comorbid depression or anxiety if trigger, SSRIs not proven although still used
  - For refractory TTM: **aripiprazole, topiramate, dronabinol, lithium, milk thistle**

White, MP and Koran, LM. *J Clin Psychopharmacol*. 2011;31(4); Lochner,C et al. *International Clinical Psychopharmacology*. 2006; 21(5); Christenson, GA et al. *J Clin Psychiatry*. 1991;52(3); Grant, JE et al. *Psychopharmacology* 2011; 218(3); Grant, JE and Odlaug, BL *J Clin Psychopharmcol.* 2015;35(3)

Excoriation (Skin Picking) Disorder

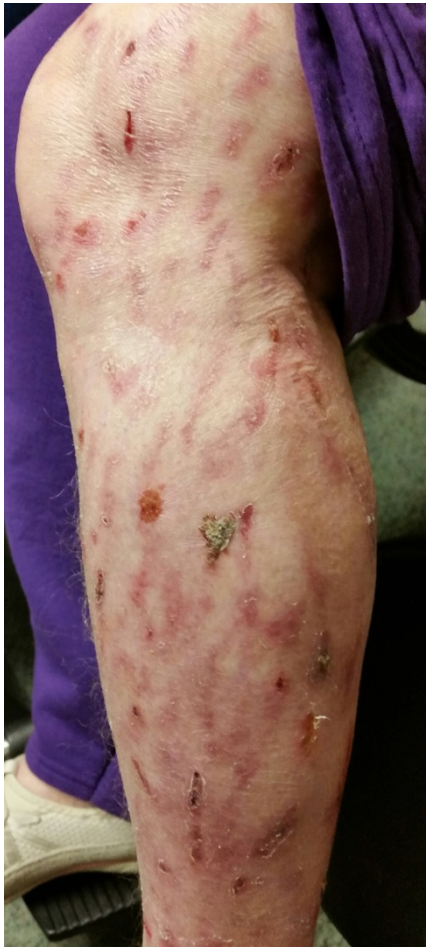
Clinical features of skin picking

- AKA compulsive skin picking, pathological skin picking, dermatotillomania, neurotic excoriations, acne excoriée, psychogenic excoriation
- Pick to the point of causing tissue damage
- Picking often blamed on underlying skin condition but some pick at nl skin
- Face, arms, legs, fingers, chest, upper back, and feet
- Prevalence 1.4%, females>>males

Grant, JE et al. *Am J Psychiatry. 2012;169*(11); Grant, JE. *Trichotillomania, skin picking, and other body-focused repetitive behaviors*. 1st ed. 2012; Keuthen, NJ. et al. *Compr Psychiatry. 2010;51*(2)

Complications of skin picking

- Spend hours daily picking
- Scarring/disfigurement
- Camouflaging/avoidance
- Social and occupational dysfunction
- Cellulitis/sepsis
- Excessive blood loss
- Paralysis



Grant, JE et al. *Am J Psychiatry. 2012;169*(11) ; Grant, JE. *Trichotillomania, skin picking, and other body-focused repetitive behaviors* .1st ed. 2012

Reasons for picking

- Triggers
  - Removing a blemish
  - Coping with negative emotions (depression, anger, anxiety)
  - Itch
  - Pleasure
  - Preceding urge
  - Feeling or looking at the skin
  - Boredom
- Varying degrees of self-awareness
  - Conscious picking
  - Automatic picking

Grant, JE et al. *Am J Psychiatry, 2012;169*(11); Grant, JE. *Trichotillomania, skin picking, and other body-focused repetitive behaviors*. 1st ed. 2012

Psychiatric comorbidity common

- MDD
- Anxiety
- OCD
- TTM
- BDD
- Substance use

Grant, JE et al. *Am J Psychiatry, 2012;169*(11) ; Grant, JE. *Trichotillomania, skin picking, and other body-focused repetitive behaviors*. 1st ed. 2012

Diagnosis of skin picking in DSM-5

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

Treatment of skin picking

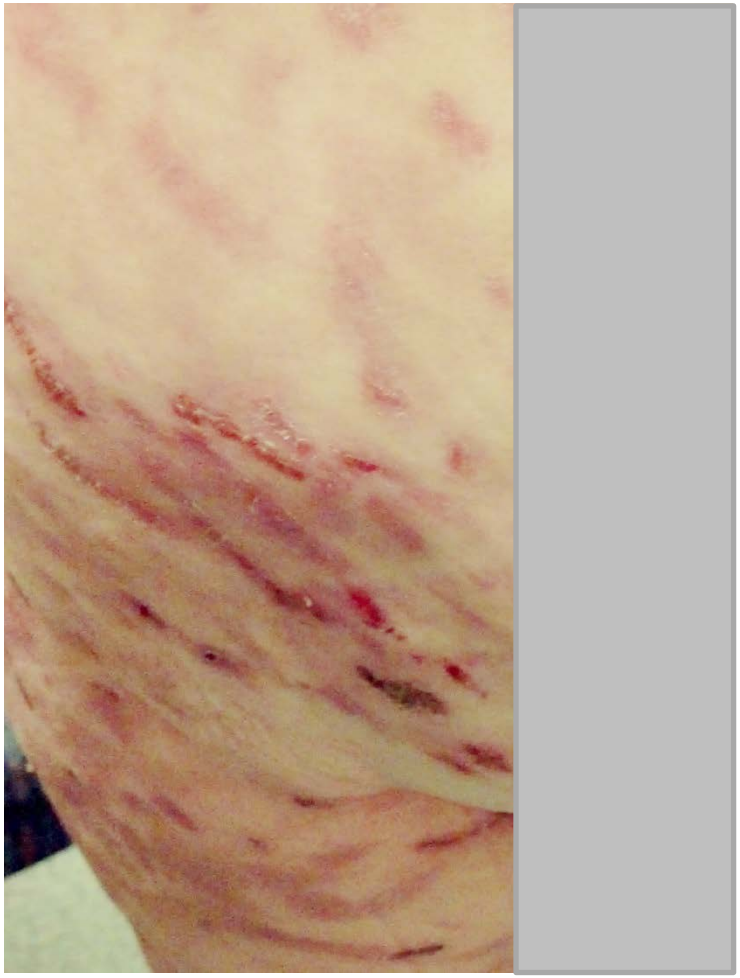
- Evaluate for primary medical or psychiatric causes of picking
  - CBC
  - CMP
  - TSH
  - Toxicology screen
  - +/- HIV
- Refer to dermatologist for evaluation, itch workup prn, skin care
- **CBT** and **SSRIs** are first-line treatments

Medication treatment of picking

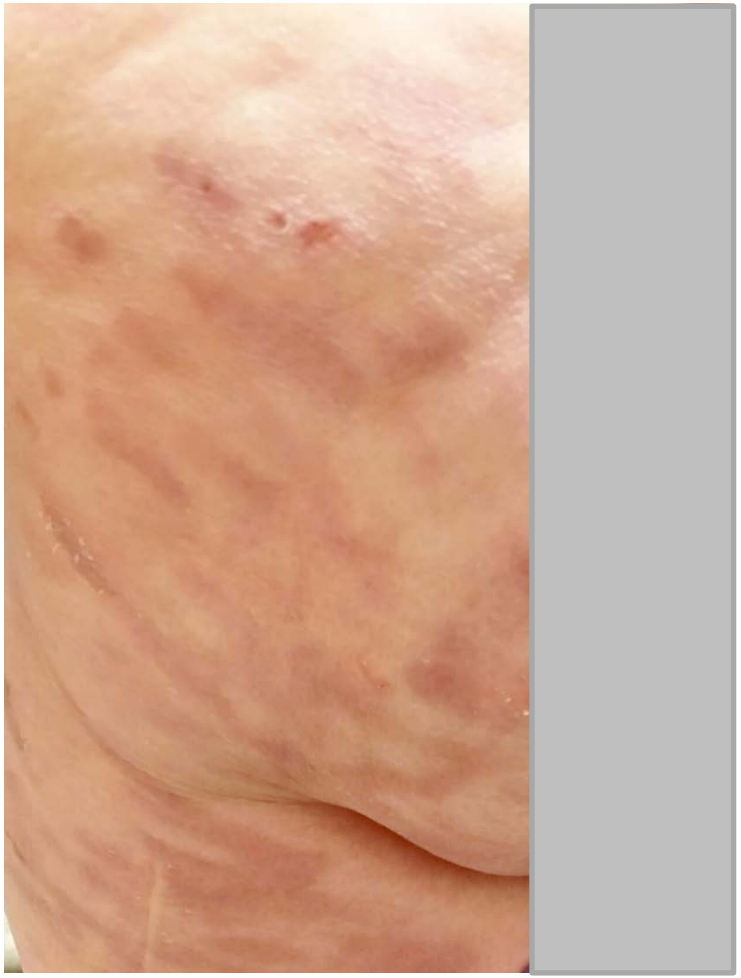
- **SSRIs beneficial**
  - 2 RCTs with fluoxetine (~55mg/d)
  - Open-label studies with fluvoxamine (~110mg/d) and escitalopram (~ 25mg/d)
  - Large case series with sertraline (75-100mg/d)
- No direct comparative studies, SSRIs thought to be equally effective
- Unlike BDD and OCD, response not delayed and high doses not required
- May also trial non-SSRI psychotropic if indicated by patient history and comorbid psychiatric disorders (TREAT THE TRIGGER)

Simeon, D et al. *J Clin Psychiatry. 1997; 58*(8); Bloch, MR. *Psychosomatics, 2001; 42*(4); Arnold, LM. *J Clin Psychopharmacol, 1999;19*(1); Keuthen, N et al J. *Int Clin Psychopharmacol, 2007;22*(5); Kalivas, J et al. Arch Dermatol. 1996;132(5)

Treating the trigger



Sertraline
Bupropion



Medication treatment of picking (cont.)

- NAC and naltrexone are not well studied (yet) in skin picking, but often used given benefit in TTM

- **N-acetylcysteine (NAC)**
  - Beneficial in case report of NAC in skin picking (1 RCT in TTM)
  - Beneficial in open-label study in skin picking in pts w/ Prader-Willi Syndrome
  - Ongoing RCT in skin picking
  - Start 600 mg PO BID x 2 wks, then 1200 mg PO BID, OTC

- **Naltrexone**
  - Case report of naltrexone showing benefit in skin picking, mixed RCTs in TTM
  - Most effective for pts with FH of addiction in TTM
  - 50-100 mg/d, monitor LFTs

Odlaug, BL & Grant, JE. *J Clin Psychopharmacol. 2007;27*(2); Miller JL and Angulo M. Med Genet A. 2014; 164A(2);
Benjamin, E & Buot-Smith, TJ. *Am Acad Child Adolesc Psychiatry. 1993;32*(4)

Medication treatment of skin picking

- Other medications
  - Olanzapine, 5mg/d (case report)
  - Aripiprazole, 5-10mg/d (3 case reports)
  - Lithium, 300-900 mg/d, (case series, n=2)
  - Milk thistle, 150mg PO BID (case series, n=3)

- Recommendations
  - No established medication guidelines
  - **CBT** and **SSRIs** are first-line treatments
  - **NAC**, **naltrexone** not well studied, routinely used and effective
  - For refractory cases: **olanzapine, aripiprazole, milk thistle, lithium**
  - TREAT THE TRIGGER

Christensen RC. *Can J Psychiatry*. 2004;49(11) ; Curtis AR, Richards RW. *Ann Clin Psychiatry*. 2007;19(3); Turner GA et al. *Innov Clin Neurosci*. 2014 Jan;11(1-2); Carter WG 3rd, Shillcutt SD. *J Clin Psychiatry*. 2006 Aug;67(8); White, MP and Koran,LM. *J Clin Psychopharmacol*. 2011;31(4); Gupta MA, *Clin Dermatol*. 2013;31(1); Grant and Odlaug, *J Clin Psychopharmcol.* 2015;35(3)

Resources for TTM and skin picking

- **Trichotillomania Learning Center, www. Trich.org**
  - Finding specialists, http://www.trich.org/treatment/treatment-provider.html
  - Online education/therapy
  - Book store
- ***TTM, Skin Picking, & Other Body-Focused Repetitive Behaviors*** by Jon Grant et al. (comprehensive overview for pts and providers)
- ***Trichotillomania, An ACT-enhanced Behavior Therapy Approach*** by Douglas Woods and Michael Twohig (CBT guide for therapists)
- ***Help for Hair Pullers*** by Nancy Keuthen, (self-guided CBT)
- **International OCD Foundation**, www.ocfoundation.org
- **Online CBT**
  - StopPicking.com
  - StopPulling.com

Hoarding Disorder

Clinical features of hoarding

- Difficulty discarding- not only worthless items
- Significant clutter
- Often includes excessive acquisition but not required
- 2-6% prevalence, no gender differences
- Variable insight

Mataix-Cols , D. *N Engl J Med.* 2014; 370 (21); Steketee, G and Frost, R. *Treatment for Hoarding Disorder : Therapist Guide*. 2nd Edition. 2013; Shadwwulf (2001). Hoarding Living Room. [Photo]. From http://commons.wikimedia.org/wiki/File:Hoarding_living_room.jpg

Serious sequelae

- Social and occupational problems
- Fire danger
- Increased risk of fall
- Injury/death from falling items
- Infestation
- Health problems from dust, mold, or pests in clutter
- Eviction, home being condemned
- Risks to neighbors
  - Spread of infestation to adjacent homes
  - Structural problems caused by weight of heavy items
  - Flooding/property damage because limited access prevents proper repair
  - Lost property value for landlords/neighbors

Mataix-Cols , D. *N Engl J Med.* 2014; 370 (21); Steketee, G and Frost, R. *Treatment for Hoarding Disorder : Therapist Guide*. Second Edition. 2013; Schmalisch, CS. (n.d.) Hoarding and Housing. From http://208.88.128.33/hoarding/housing_services.aspx

Diagnosis of hoarding in DSM-5

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

Assessment of hoarding

Scales

- Saving Inventory-Revised (SI-R)
- Clutter Image Rating (CIR)

Frost, R, et al. *Behav Res Ther. 2004. 42*(10) ; Frost, R et al. *Psychopath and Behav Assess,* 2008 *;30* ; Clutter Image Rating. (n.d.). [Photo] . From http://global.oup.com/us/companion.websites/umbrella/treatments/hidden/pdf/CIR_photos.pdf with permission from Dr. Gail Steketee

Treatment of hoarding

- **CBT** is main treatment
- Medication studies inconsistent and very limited
- **SRIs/SNRIs**
  - SRIs initially thought to be ineffective in hoarding but now being reconsidered
  - Earlier studies excluded pts w/ hoarding who did not have other OCD sx , not representative
  - Paroxetine (~40 mg/d) beneficial in open-label study (n=79), hoarding OCD patients responded as well as non-hoarding OCD patients
  - Venlafaxine ER (~200 mg/d) beneficial in open-label study (n=24), DSM-5 criteria
- **Other medications**
  - Small case series (n=4) of methylphenidate ER (~50 mg/d), DSM-5 criteria

Saxena, S et al. *J Psychiatr Res. 2007;41*(6); Saxena, S & Sumner, J *Int Clin Psychopharmacol.* 2014; *29*(5); Rodriguez, CI et al. *J Clin Psychopharmacol. 2013; 33*(3)

CBT for hoarding

Skills training

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

Cognitive restructuring

- Identify and challenge beliefs that maintain hoarding

Exposure to discarding and nonacquiring

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

Steketee, G and Frost, R. *Treatment for Hoarding Disorder : Therapist Guide*. Second Edition. 2013

Treatment of hoarding

Team approach

Home visits

Forced interventions not recommended

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

Recommendations for hoarding

- Refer for CBT/hoarding team
- No medication guidelines exist, consider venlafaxine/SRI trial
- Resources
  - ***Treatment of Hoarding*** by Gail Steketee and Randy Frost (CBT guide for therapists)
  - ***Buried in Treasure*** by David Tolin et al. (self-guided CBT)
  - Finding specialists:
    - https://www.masshousing.com/portal/server.pt/gateway/PTARGS_0_2_11093_0_0_18/Hoarding_Resource_Directory.pdf
    - International OCD Foundation, www.ocfoundation.org
  - Additional resources at MassHousing.com

Conclusions

- Obsessive-compulsive related disorders (OCRDs) are common, yet underrecognized and can lead to significant dysfunction and suffering
- Screen your pts
- CBT is a key treatment for all OCRDs
- SRIs beneficial in BDD, skin picking; unclear benefit in hoarding, TTM
- Stimulus control/NAC for TTM and skin picking
- No medications have FDA approval for treating OCRDs
- Much more work needed on medication treatments for OCRDs

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