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)

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

NUMBER OF PUBMED ENTRIES

- OCD: ~17,000
- BDD: ~1,300
- Skin-Picking: ~400
- Hair-Pulling: ~1,300
- Hoarding: ~1,200
New OCD chapter in DSM-5

**DSM-IV-TR**

**Anxiety Disorders**
- OCD (Hoardinging)

**Somatoform Disorders**
- Body Dysmorphic Disorder

**Impulse Control Disorders**
- Trichotillomania
- Impulse Control Disorder NOS (Skin Picking)

**DSM-5**

**OC and Related Disorders**
- OCD
- Body Dysmorphic Disorder
- Trichotillomania
- Skin-Picking Disorder
- Hoarding Disorder
- Substance-Induced OCRD
- OCRD Due to a Medical Condition
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

Clinical features of BDD (cont.)

- Repetitive behaviors
  - Mirror checking
  - Excessive grooming
  - Camouflaging
  - Comparing
  - Reassurance seeking

- Avoidance, may be housebound

- SI common
BDD is common

- 2.4% prevalence in general population (women>men)
- 12%, outpatient dermatology clinic
- 33%, pts seeking rhinoplasty
Diagnosis of BDD in DSM-5

- Preoccupation with perceived defects in physical appearance that are not observable or appear slight to others

- Individual performs repetitive behaviors (e.g. mirror checking) or mental acts (e.g. comparing appearance) in response to concerns

- Causes significant distress or impairment

- Not better explained by an eating disorder (e.g. concerns with body fat or weight)

Specify insight (good/fair, poor, or absent/delusional)
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 good insight, provide diagnosis and psychoeducation
- For pts with poor insight or delusional BDD:
  - Postpone diagnosis until alliance has been built
  - Postpone cosmetic procedures
  - Target medications to psychiatric sx or areas of dysfunction

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

SRIs for BDD

• **SRIs** effective
  – Clomipramine, ~140 mg/d, RCT
  – Fluoxetine, ~80 mg/d, RCT
  – Escitalopram, ~30 mg/d, open-label study and RCT
  – Citalopram, ~50 mg/d, open-label study
  – Fluvoxamine, ~210-240 mg/d, two open-label studies

• No direct comparative studies, SRIs thought to be equally effective

• **Response delayed** (10-12 weeks for full effect)

• **High doses** often required

• **Rapid titration** recommended

• Effective for patients with delusional BDD

## Which SRI?

<table>
<thead>
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<th>Drug Name</th>
<th>Target Dose</th>
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<tr>
<td>Escitalopram</td>
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<tr>
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<td>Fluoxetine</td>
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<td>300 mg/d</td>
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<tr>
<td>Clomipramine</td>
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### Higher than max SRI dosing

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<td>Sertraline</td>
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<tr>
<td>Paroxetine</td>
<td>60 mg/d</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>300 mg/d</td>
</tr>
<tr>
<td>Clomipramine</td>
<td>250 mg/d (not recommended)</td>
</tr>
</tbody>
</table>

(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** (60 mg 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
    - Typical antipsychotic pimozide, not efficacious in RCT
  - **Clomipramine**, beneficial in 4 case reports, ~125 mg/d
    - Start low dose (25-50 mg) and monitor EKG and level while titrating

- **Other monotherapies:**
  - Venlafaxine effective in small open-label study, ~150-225 mg/d
Suggested medication approach for BDD

INCREASE SRI UNTIL SX RESOLVE OR MAX DOSE

NO RESPONSE TO SRI

SWITCH TO DIFFERENT SRI

PARTIAL RESPONSE TO SRI

INCREASE SRI>MAX

• Escitalopram, 30 mg/d
• Sertraline, 300 mg/d
• Fluoxetine, 120 mg/d

AUGMENTATION

• Buspirone
• Antipsychotic (Aripiprazole?)
• Clomipramine

CBT for BDD

Cognitive restructuring

• Challenge negative thoughts related to appearance

Response (ritual) prevention

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

Behavioral experiments

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

Exposures

• Face situations which might normally be avoided

Resources for BDD

- **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
Excoriation (Skin-Picking) Disorder
Clinical features of skin picking

- AKA compulsive or pathological skin picking, dermatotillomania, neurotic excoriations, acne excoriée, psychogenic excoriation
- Recurrent skin picking leading to tissue damage
- Picking often blamed on underlying skin condition but some pick at normal skin
- Face, arms, legs, fingers, chest, upper back, and feet
- Prevalence 1.4%, females>>males
- Less than 20% of pts who pick actually seek treatment
Complications of skin picking

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

Triggers for picking

- Triggers
  - Removing a blemish
  - Coping with negative emotions (depression, anger, anxiety)
  - Boredom (idle hands)
  - Itch
  - Pleasure
  - Preceding urge
  - Feeling or looking at the skin

- Varying degrees of self-awareness
  - Conscious picking
  - Automatic picking

Psychiatric comorbidity common

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

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 or medical condition (e.g. amphetamine, cocaine, 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

• **CBT** is first-line

• Medication studies limited, **SSRIs and N-acetylcysteine** effective

• Consider dermatology referral
  – Skin care and evaluation (e.g. itch w/u)
  – Treatment of dermatologic triggers for picking (e.g. acne, keratosis pilaris)

• Consider labwork for medical or psychiatric causes of picking
  – CBC
  – CMP
  – TSH
  – Toxicology screen
  – +/- HIV

CBT for skin picking (and hair pulling)

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

**Cognitive restructuring**
- Challenge maladaptive thoughts related to picking/pulling

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

Stimulus control

http://store.trich.org/
Medication treatment of picking

• **SSRIs** effective
  – 2 RCTs with fluoxetine (~55 mg/d)
  – Open-label studies with fluvoxamine (~110 mg/d) and escitalopram (~25 mg/d)
  – Large case series with sertraline (75-100 mg/d)
  – No direct comparative studies, SSRIs thought to be equally effective
  – Unlike BDD and OCD, response not delayed and high doses not required

• **N-acetylcysteine (NAC),** 1200mg PO BID
  – OTC glutamatergic modulator
  – Addiction, gambling, OCD, schizophrenia, BPAD
  – Significant improvement in RCT of pts w/ skin picking and RCT of hair pulling
  – Beneficial in open-label study of skin picking in pts w/ Prader-Willi Syndrome
  – Start 600 mg PO BID x 2 wks, then 1200 mg PO BID

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Other medications for skin picking

• **Naltrexone**, 50-100 mg/d
  - Opioid antagonist
  - Not well studied in skin picking (single case report), but *often used* given benefit in hair pulling
  - Very effective for canine acral lick dermatitis
  - Alcohol and opioid dependence, kleptomania, gambling
  - Hepatotoxicity with doses >300 mg/d, check LFTs 1m, 3m, 6m, yearly

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

TREAT THE TRIGGER: consider other medications as indicated by pt sx and hx

Other medications for picking (cont.)

Bupropion added to SSRI
Recommendations for skin picking

• Refer for CBT, introduce stimulus control

• Medication studies limited, no established medication guidelines

• Consider trial of **SSRI** when comorbid depression, anxiety or **NAC**

• **Naltrexone** not well studied, but routinely used

• For refractory cases: **olanzapine, aripiprazole, milk thistle, lithium or other medications that might treat the trigger as indicated by hx**
Trichotillomania (TTM)
Clinical features of TTM

• Excessive hair pulling resulting in hair loss

• Most often on scalp and eyebrows but may be anywhere including lashes, pubic hair, and others

• ~0.6-1.2% prevalence
Clinical features of TTM (cont.)

- Classic irregular hair pattern
- NL hair density
- Hairs of varying length
- No scaling
- Pulling for hours daily
- Shame/avoidance
- Social and occupational dysfunction

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

- Early satiety
- N/V
- Abdominal pain
- Weight loss
Triggers for pulling

- Triggers
  - Coping with negative emotions (depression, anger, anxiety)
  - Hairs not feeling right
  - Aesthetics (removing gray hairs, evening out eyebrows)
  - Boredom (idle hands)
  - Itch or other sensory trigger

- Varying degrees of self-awareness
  - Conscious pulling
  - Automatic pulling

Grant JE. *Trichotillomania, skin picking, and other body-focused repetitive behaviors* 1st ed. 2012
Diagnosis of TTM in DSM-5

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

- **CBT** is first-line

- Medication studies limited, **NAC** and **olanzapine** effective

- Contrary to OCD, BDD, and skin picking, benefit of SRIs for TTM unclear
  - **Clomipramine (CMI)**
    - ✓ Double blind crossover study of TTM showed CMI >> desipramine (~180 mg/d)
    - ✗ In placebo-controlled RCT, CMI doesn’t differentiate from placebo (~100 mg/d)
  
  - **SSRIs**
    - ✓ Hair pulling significantly reduced in 3 open-label studies (fluoxetine, citalopram, escitalopram)
    - ✗ No change in hair pulling in 3 RCTs (fluoxetine x 2, sertraline) and open-label trial of fluvoxamine

Medication treatment of TTM

• **N-acetylcysteine (NAC)**, 1200 mg PO BID
  – Significantly improves TTM in RCT (robust)
  – OTC, 600mg PO BID x 2 wks, then 1200mg PO BID

• **Olanzapine**, 10 mg/d
  – Significantly improves TTM in RCT (robust)
  – Use tempered by long-term metabolic risks
  – Open-label study of aripiprazole (n=12), ~7.5 mg/d, 58% response rate

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

Other medications for TTM

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

• Case series/reports
  – **Lithium**, (n=10), 900-1500 mg/d
  – **Silymarin**, aka milk thistle, (n=3), 150 mg PO BID
  – **Bupropion XL**, (n=2), 300-450 mg/d
Recommendations for TTM

• Refer for CBT, introduce stimulus control

• Medication studies limited, no established medication guidelines

• Consider trial of **NAC** (preferred)/ **naltrexone** (FH of addiction)/ **olanzapine**

• **SRIs** not proven, although used when depression and anxiety are triggers for pulling

• For refractory TTM: **aripiprazole, topiramate, dronabinol, lithium, milk thistle, bupropion**, or other medications that might treat the trigger as indicated by hx
Resources for skin picking and TTM

- **Trichotillomania Learning Center, www.Trich.org**
  - 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

Effective treatments for Hoarding Disorder are available. The following strategies may be beneficial, depending on the specific needs of the individual:

- Behavioral interventions: Encourage clients to engage in goal-setting, problem-solving, and reward systems to help manage urges to hoard.
- Cognitive-behavioral therapy (CBT): Focus on identifying and challenging negative thought patterns that contribute to hoarding behavior.
- Medications: Several medications have shown promise in treating symptoms of hoarding disorder, including selective serotonin reuptake inhibitors (SSRIs).
- Support groups: Connecting with others who share similar experiences can provide emotional support and practical advice.
- Home organization and decluttering: Collaborate with clients to create a plan for decluttering and maintaining a tidy environment.

For further reading, consider the following resources:

Diagnosis of hoarding in DSM-5

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

Scales

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

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 pts responded as well as non-hoarding OCD pts on YBOCS and show significant reduction in hoarding
  - **Venlafaxine ER** (~200 mg/d) beneficial in open-label study (n=24), DSM-5 hoarding criteria

- **Other medications**
  - Small case series (n=4) of **methylphenidate ER** (~50 mg/d), DSM-5 hoarding criteria

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

Treatment tips for hoarding

Team approach

Home treatment

Forced interventions not recommended

Recommendations/resources 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

• OCRDs are common, yet underrecognized and can lead to significant dysfunction and suffering

• CBT is a key treatment for all OCRDs

• Stimulus control can rapidly lessen skin picking and TTM - introduce it early

• No medications have FDA approval for treating OCRDs

• SRIs beneficial in BDD, skin picking; unclear benefit in hoarding, TTM

• Consider NAC for skin picking and TTM

• Screen your pts