Treatment of Obsessive-Compulsive Related Disorders

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Obsessive-Compulsive Related Disorders (OCRDs)

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

NUMBER OF PUBMED ENTRIES

- OCD: ~18,000
- BDD: ~1600
- Skin-Picking: ~400
- Hair-Pulling: ~1400
- Hoarding: ~1300
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
“Snapchat (Selfie) Dysmorphia”

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
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
- **SSRIs** and **CBT** are first-line treatments

SRIs for BDD

• Serotonin reuptake inhibitors (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

• High doses often required

• Initial selection based on side effect profile

# Which SRI?

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Target Dose</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td>Escitalopram</td>
<td>20 mg/d</td>
<td></td>
</tr>
<tr>
<td>Sertraline</td>
<td>200 mg/d</td>
<td></td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>80 mg/d</td>
<td>Drug interactions</td>
</tr>
<tr>
<td>Citalopram</td>
<td>40 mg/d</td>
<td>Potential ↑QTc&lt;br&gt;Reduced max dose may not be sufficient in BDD</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>60 mg/d</td>
<td>Sedation, weight gain, short half-life</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>300 mg/d</td>
<td>Sedation</td>
</tr>
<tr>
<td>Clomipramine</td>
<td>250 mg/d</td>
<td>Sedation, constipation, urinary retention, HoTN, ↑QTc&lt;br&gt;seizures, drug interactions, weight gain&lt;br&gt;Considered second-line</td>
</tr>
</tbody>
</table>
SSRI trial in BDD

- **High doses** (maximum or higher) often required

- **Response delayed** (10-12 wks for full effect)

- **Rapid titration** recommended (reach maximum dose by wk 5-9)

- **Trial length:** 12 wks

- **Duration of treatment** (not well-studied)
  - Only one relapse study to date, 40% relapse if SSRI stopped <6 mo
  - given lethality of BDD, SSRI recommended several years or longer

Higher than max SSRI dosing in BDD

<table>
<thead>
<tr>
<th>Drug</th>
<th>FDA Max Dose</th>
<th>Reported BDD &gt;max dosing</th>
<th>My max dosing</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>Escitalopram</td>
<td>20 mg/d</td>
<td>Up to 50 mg/d</td>
<td>30 mg/d</td>
<td>Check EKG</td>
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<td>Sertraline</td>
<td>200 mg/d</td>
<td>Up to 400mg/d</td>
<td>300mg/d</td>
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<tr>
<td>Fluoxetine</td>
<td>80 mg/d</td>
<td>Up to 100mg/d</td>
<td>120 mg/d</td>
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</tr>
<tr>
<td>Paroxetine</td>
<td>60 mg/d</td>
<td>Up to 100mg/d</td>
<td>80 mg/d</td>
<td></td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>300 mg/d</td>
<td>Up to 400 mg/d</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citalopram</td>
<td>40 mg/d</td>
<td>Up to 100mg/d</td>
<td>80 mg/d</td>
<td>High dosing controversial given QTc prolongation risk, I consider with EKG, h/o failed medication trials, pt consent</td>
</tr>
<tr>
<td>Clomipramine</td>
<td>250 mg/d</td>
<td></td>
<td></td>
<td>Above max dosing not recommended due to seizure risk</td>
</tr>
</tbody>
</table>

No guidelines on above maximum dosing in BDD exist – doses circled are generally well-tolerated in my practice
Other medications for BDD

- SSRI augmentation:
  - Limited studies, very few options
  - **Buspirone** (60 mg TDD) shows benefit in open-label study and chart-review study
  - Atypical antipsychotics—not well studied but sometime used
    - **Aripiprazole**, beneficial in 1 case report, 10 mg/d
    - **Risperidone**, beneficial in 1 case report, 4 mg/d
    - Olanzapine, mixed case reports (2 robust, 6 no effect), ~5 mg/d
    - In chart review study, only 15% respond to antipsychotic augmentation but effect size large
    - 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** monotherapy effective in small open-label study, ~150-225 mg/d
  - **Keppra** monotherapy effective in small open-label study, ~1000mg PO BID
Suggested medication approach to BDD

**NO RESPONSE TO SSRI**
- **SWITCH TO DIFFERENT SSRI**
  - **SWITCH TO CLOMIPRAMINE OR VENLAFAXINE**

**PARTIAL RESPONSE TO SSRI**
- **INCREASE SSRI>MAX**
  - Escitalopram, 30 mg/d
  - Sertraline, 300 mg/d
  - Fluoxetine, 120 mg/d

**AUGMENT**
- **Buspirone**
- Antipsychotic
- Clomipramine
- CBT

**INCREASE SSRI UNTIL SX RESOLVE OR TO MAXIMUM/ HIGHEST TOLERABLE DOSE FOR 12WKS**
Delusional BDD

• Do not reassure pt that they look fine
• Postpone diagnosis until alliance has been built
• Postpone cosmetic procedures
• Medication:
  – Antipsychotic monotherapy NOT proven to be effective
  – SSRIs are effective for patients with delusional BDD and considered 1st line
  – Pitch medications to other psychiatric sx (e.g depression, anxiety, sleep)
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

➢ RCT comparing CBT to waitlist shows 81% responder rate with CBT

Etiology of BDD

Imagine that this sales clerk is looking in your direction

What is her facial expression?

Neutral  Contempt  Happiness  Surprise  Sadness  Anger  Fear  Disgust

Buhlmann. J Psychiatr Res. 2006;40
Subjects with BDD

Imagine that this sales clerk is looking in your direction.

What is her facial expression?

Neutral  Contempt  Happiness  Surprise  Sadness  Anger  Fear  Disgust

Buhlmann. J Psychiatr Res. 2006;40
Imagine that this sales clerk is looking in your friend’s direction

What is her facial expression?

Neutral  Contempt  Happiness  Surprise  Sadness  Anger  Fear  Disgust
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.iocdf.org

- **Residential treatment**
  - McLean OCDI Institute, www.mcleanhospital.org/programs/ocd-institute-ocdi
  - Rogers OCD Center, rogersbh.org/what-we-treat/ocd-anxiety/ocd-and-anxiety-residential-services/ocd-center
  - Others...
Excoriation (Skin-Picking) Disorder
Clinical features of skin picking

- Prevalence 1.4-5.4%
- Women >> men
- <20% of pts who pick actually seek treatment
- Triggers
  - Removing a blemish
  - Coping with negative emotions (depression, anger, anxiety)
  - Boredom (idle hands)
  - Itch
  - Pleasure
- Varying degrees of self-awareness
  - Focused picking
  - Automatic picking

Complications of picking

- Scarring/disfigurement
- Avoidance
- Social and occupational dysfunction
- Cellulitis/sepsis
- Excessive blood loss
- Paralysis

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 due to a substance (e.g. amphetamine, cocaine)
  - Substance-induced OCRD, e.g. Cocaine-induced OCRD
- Not due to a medical condition (e.g. HoTH, liver disease, uremia, lymphoma, HIV, scabies, atopic dermatitis, blistering skin disorders)
  - OCRD due to a medical condition, e.g. OCRD due to HIV with skin picking
- Not secondary to another mental disorder (e.g. delusions of parasitosis)
Treatment of skin picking

- Clinically, **CBT considered 1st line** but no studies comparing meds to CBT

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

- Consider dermatology referral
  - Skin care
  - Treatment of dermatologic triggers for picking (e.g. acne, itch)

- For moderate-severe cases or if indicated by clinical hx, check labs
  - CBC
  - CMP
  - TSH
  - Tox screen
  - +/- HIV

CBT for skin picking (and hair pulling)

Habit reversal
- Awareness training: identify stimuli for picking or pulling
- Competing response: replace picking/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/
New devices for awareness training

https://www.habitaware.com/
## Efficacy of CBT in skin picking

<table>
<thead>
<tr>
<th></th>
<th>Therapy</th>
<th>Waitlist</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HRT</strong></td>
<td>77% reduction in picking</td>
<td>16% reduction in picking</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Brief CBT</strong></td>
<td>57% recovery</td>
<td>6.7% recovery</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Effect size 1.52</td>
<td>Effect size .26</td>
<td></td>
</tr>
</tbody>
</table>

First-line medications for skin picking

- **SSRIs** can be effective
  - 2 RCTs with fluoxetine (\(~55 \text{ mg/d}\)), fluoxetine>placebo
  - Fluvoxamine (\(~110 \text{ mg/d}\)) and escitalopram (\(~25 \text{ mg/d}\)) showing benefit in open-label studies
  - Large case series (n=31) of sertraline (\(~100 \text{ mg/d}\)) with 68% response rate
  - RCT with citalopram 20mg/d, citalopram=placebo but study only 4 weeks
  - No direct comparative studies, SSRIs thought to be equally effective
  - Unlike BDD and OCD, response not delayed and high doses not required (8wk trial advised)

- **N-acetylcysteine (NAC)**
  - 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 (>6 week trial advised)
  - Preferred to SSRI if no comorbid depression or anxiety

Second-line medications for skin picking

- **Naltrexone**, 50-100 mg/d
  - Opioid antagonist
  - Alcohol and opioid use, kleptomania, gambling
  - Only 1 case report in skin picking, but often used given benefit in TTM and canine acral lick dermatitis
  - Hepatotoxicity with doses >300 mg/d, check LFTs 1m, 3m, 6m, yearly

- **Others**
  - **Topiramate**, 25-200 mg/d (open-label study, n=10), robust improvement
  - **Olanzapine**, 5 mg/d (case report)
  - **Risperidone**, 1.5 mg/d (case report)
  - **Aripiprazole**, 5-10 mg/d (3 case reports)
  - **Lithium**, 300-900 mg/d (case series, n=2)
  - **Riluzole**, 100mg PO BID, (case report), monitoring LFTs and febrile illness
  - **Silymarin**, from milk thistle, 150-300mg PO BID (case series, n=3), drug interactions
  - **Inositol**, 6g PO TID (case series, n=3), taken in powder form

Trichotillomania (TTM)
Clinical features of TTM

- ~0.6-3.4% prevalence
- Women >> men
- Hair pulling most often on scalp and eyebrows but may be anywhere including lashes, pubic hair, and others
- Often hours daily
- Shame/avoidance
- Social and occupational dysfunction

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
  – Focused pulling
  – Automatic pulling
• Classic irregular hair pattern
• Hairs of varying length
• Normal hair density
• No scaling
Trichotillophagia

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

Trichobezoar

Gaujoux. *World J Gastrointest Surg.* 2011;3; Photo from Gaujoux. *World J Gastrointest Surg.* 2011;3; (CC) 2011, by CC BY-NC 4.0 license, https://creativecommons.org/licenses/by-nc/4.0/legalcode
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

# Efficacy of CBT in TTM

## Response rates in TTM

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Waitlist</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ninan, 2000</td>
<td>CBT 71%</td>
<td>Clomipramine 100mg/d 40%</td>
</tr>
<tr>
<td>Van Minnen, 2003</td>
<td>BT 64%</td>
<td>Fluoxetine 60mg/d 9%</td>
</tr>
<tr>
<td>Woods, 2006</td>
<td>ACT/HRT 66%</td>
<td>NA</td>
</tr>
</tbody>
</table>

(BT, behavioral therapy; ACT/HRT, acceptance and commitment therapy-enhanced habit reversal treatment)

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First-line medications for TTM

- **N-acetylcysteine (NAC),** 1200 mg PO BID
  - Significantly improves TTM in RCT (56% response rate)
  - OTC, 600mg PO BID x 2 wks, then 1200mg PO BID

- **Olanzapine,** 10 mg/d
  - Significantly improves TTM in RCT (85% response rate)
  - 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

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Second-line medications for TTM

• Open-label studies
  – **Topiramate** (n=14), ~160 mg/d
  – **Abilify** (n=12), ~7.5 mg/d,
  – **Dronabinol** (n=14), 2.5-5 mg PO BID, RCT ongoing now

• Others
  – **Lithium**, 900-1500 mg/d (case series, n=10)
  – **Silymarin**, milk thistle, 150 mg PO BID (case series, n=3), drug interactions
  – **Bupropion XL**, 300-450 mg/d (case series, n=2)
  – **Inositol**, 6g PO TID (case series, n=3 but not recent RCT)
BFRB Precision Medicine Initiative

• Multi-site initiative to apply precision medicine to skin picking and hair pulling (Mass Gen. Hosp., UCLA, University of Chicago)

• Approach:
  1) Study hundreds of individuals by clinical interview, computerized tasks, imaging, bloodwork
  2) Identify BFRB profiles from patterns of pulling/picking
  3) Match profiles with genetic/imaging data
  4) Tailor treatments to genetic and biologic factors

• First 300 pts already enrolled, privately funded

BFRB, body-focused repetitive behaviors
In the human Sapap3 gene, 4/6 SNPs are associated with grooming disorders but not OCD.
Resources for skin picking and TTM

- **TLC Foundation for Body-Focused Repetitive Behaviors**, www.bfrb.org

- **TTM, Skin Picking, & Other Body-Focused Repetitive Behaviors** by Jon Grant et al. (comprehensive overview for pts and providers)

- **Help for Hair Pullers** by Nancy Keuthen (self-guided CBT)

- **Online CBT**
  - StopPicking.com
  - StopPulling.com
Hoarding Disorder
Clinical features of hoarding

- Difficulty discarding - not only worthless items
- Significant clutter
- Often includes excessive acquisition
- 2-6% prevalence, men=woman
- 50% comorbid MDD, 28% ADHD, inattentive type
- Variable insight

Serious sequelae

- Health problems from dust, mold, or pests in clutter
- Injury/death from falling items, structural dangers, fire
- Removal of children/dependent adults
- Homelessness due to eviction
- Social and occupational problems
- Risks to neighbors (infestation, property damage, lost property value)

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, or absent/delusional
Assessment of hoarding

- Clutter Image Rating Scale (CIR)
- Activities of Daily Living-Hoarding Scale (ADL-H)
- Assessing Safety
Treatment of hoarding

CBT is main treatment, no well-established medication treatments

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

➢ RCT of CBT vs. waitlist, 41% show significant clinical improvement w/ large effect sizes on hoarding scales
Medication treatment of hoarding

• SRIs initially thought to be ineffective 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 used for selection

• **Other medications**
  – Small case series (n=4) of **methylphenidate ER** (~50 mg/d), 50 % show modest reduction in hoarding sx despite not having ADHD, DSM-5 hoarding criteria used for selection

Treatment tips for hoarding

- Team approach
- Animal hoarding
- Forced interventions not recommended

Resources for hoarding

• *Treatment of Hoarding* by Gail Steketee and Randy Frost (CBT guide for therapists)

• *Buried in Treasure* by David Tolin et al. (self-guided CBT)

• Specialists and other resources
  – IOCDF Hoarding Center, hoarding.iocdf.org
  – Mass Housing, MassHousing.com/hoarding
  – Regional/city hoarding task forces
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 OCD, BDD, skin picking; unclear benefit in hoarding, TTM.
- Consider NAC for skin picking and TTM.
- Screen your pts.