ICD-11 DIAGNOSTIC GUIDELINES

Obsessive-Compulsive or Related Disorders

Note: This document contains a pre-publication version of the ICD-11 diagnostic guidelines for Obsessive-Compulsive or Related Disorders. There may be further edits to these guidelines prior to their publication.

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OBSESSIVE-COMPULSIVE OR RELATED DISORDERS

Obsessive-Compulsive or Related Disorders comprise a group of disorders characterized by repetitive thoughts and behaviours. Although these disorders also have some features in common with disorders in other groupings (e.g., Anxiety or Fear-Related Disorders), the disorders included in the grouping of Obsessive-Compulsive or Related Disorders have commonalities on key diagnostic validators and frequently co-occur, which may be partly related to shared genetic factors.

Cognitive phenomena such as obsessions, intrusive thoughts, and preoccupations are central to a subset of these conditions (i.e., Obsessive-Compulsive Disorder, Body Dysmorphic Disorder, Hypochondriasis, and Olfactory Reference Disorder) and are accompanied by related repetitive behaviours. Hoarding Disorder is not associated with intrusive unwanted thoughts but rather is characterized by a compulsive need to accumulate possessions and distress related to discarding them. Also included in the grouping are Body-Focused Repetitive Behaviour Disorders, which are primarily characterized by recurrent and habitual actions directed at the integument (e.g., hair pulling, skin picking) and lack a prominent cognitive aspect.

Obsessive-Compulsive or Related Disorders include the following:

6B20 Obsessive-Compulsive Disorder
6B21 Body Dysmorphic Disorder
6B22 Olfactory Reference Disorder
6B23 Hypochondriasis (Health Anxiety Disorder)
6B24 Hoarding Disorder
6B25 Body-Focused Repetitive Behaviour Disorders
  6B25.0 Trichotillomania (Hair Pulling Disorder)
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6B2Y Other Specified Obsessive-Compulsive or Related Disorders

The level of insight an individual has with respect to disorder-specific beliefs varies and can be specified for those Obsessive-Compulsive or Related Disorders in which cognitive phenomena are a key aspect of clinical phenomenology. These include: Obsessive Compulsive Disorder, Body Dysmorphic Disorder, Olfactory Reference Disorder, Hypochondriasis, and Hoarding Disorder. The level of insight may be specified as ‘fair to good’ or ‘poor to absent’, as described for each of these disorders.

6B20 Obsessive-Compulsive Disorder

Essential (Required) Features:

- Presence of persistent obsessions and/or compulsions.
  - Obsessions are repetitive and persistent thoughts (e.g., of contamination), images (e.g., of violent scenes), or impulses/urges (e.g., to stab someone) that are experienced as intrusive and unwanted, and are commonly associated with

anxiety. The individual typically attempts to ignore or suppress obsessions or to neutralize them by performing compulsions.
    - Compulsions are repetitive behaviours or rituals, including repetitive mental acts, that the individual feels driven to perform in response to an obsession, according to rigid rules, or to achieve a sense of 'completeness'. Examples of overt behaviours include repetitive washing, checking, and ordering of objects. Examples of analogous mental acts include mentally repeating specific phrases in order to prevent negative outcomes, reviewing a memory to make sure that one has caused no harm, and mentally counting objects. Compulsions are either not connected in a realistic way to the feared event (e.g., arranging items symmetrically to prevent harm to a loved one) or are clearly excessive (e.g., showering daily for hours to prevent illness).
- Obsessions and compulsions are time-consuming (e.g., take more than 1 hour per day) or result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.
- The symptoms or behaviours are not a manifestation of another medical condition (e.g., basal ganglia ischemic stroke) and are not due to the effect of a substance or medication on the central nervous system (e.g., amphetamine), including withdrawal effects.

Insight qualifiers:

Individuals with Obsessive-Compulsive Disorder vary in the degree of insight they have about the accuracy of the beliefs that underlie their obsessive-compulsive symptoms. Although many can acknowledge that their thoughts or behaviours are untrue or excessive, some cannot, and the beliefs of a small minority of individuals with Obsessive-Compulsive Disorder may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (e.g., an individual is convinced that she will become seriously ill if she does not maintain her washing rituals). Insight may vary substantially even over short periods of time, for example depending on the level of current anxiety or distress, and should be assessed with respect to a time period that is sufficient to allow for such fluctuation (e.g., a few days or a week). The degree of insight that an individual exhibits in the context of Obsessive-Compulsive Disorder can be specified as follows:

6B20.0 Obsessive-Compulsive Disorder with fair to good insight

- Much of the time, the individual is able to entertain the possibility that their disorder-specific beliefs may not be true and they are willing to accept an alternative explanation for their experience. This qualifier level may still be applied if, at circumscribed times (e.g., when highly anxious), the individual demonstrates no insight.

6B20.1 Obsessive-Compulsive Disorder with poor to absent insight

- Most or all of the time, the individual is convinced that the disorder-specific beliefs are true and they cannot accept an alternative explanation for their experience. The

lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.

Additional Clinical Features:

- The content of obsessions and compulsions varies among individuals and can be grouped into different themes or symptom dimensions, including: cleaning (i.e., contamination obsessions and cleaning compulsions); symmetry (i.e., symmetry obsessions and repeating, ordering, and counting compulsions); forbidden or taboo thoughts (e.g., aggressive, sexual, and religious obsessions) and related compulsions. Some individuals have difficulties discarding objects and accumulate (i.e., hoard) them as a consequence of typical obsessions, such as fears of harming others (see Boundary with Other Obsessive-Compulsive or Related Disorders, under Hoarding Disorder). Individuals usually manifest symptoms on more than one dimension.
- Although compulsions are not done for pleasure, their performance may result in temporary relief from anxiety or distress or a temporary sense of completeness.
- Individuals with Obsessive-Compulsive Disorder experience a range of affect when confronted with situations that trigger obsessions and compulsions. These affects can include marked anxiety or panic attacks, strong feelings of disgust, or a distressing sense of 'incompleteness' or uneasiness until things look, feel, or sound 'just right'.
- Individuals with Obsessive-Compulsive Disorder often avoid people, places, and things that trigger obsessions and compulsions.
- Common beliefs in Obsessive-Compulsive Disorder include an inflated sense of responsibility, overestimation of threat, perfectionism, intolerance of uncertainty, and overvaluation of the power of thoughts (e.g., believing that having a forbidden thought is as bad as acting on it).
- The severity of Obsessive-Compulsive Disorder symptomatology varies such that some individuals spend a few hours per day obsessing or engaging in compulsions, whereas others have near constant intrusive thoughts or compulsions that can be incapacitating.
- When both obsessions and compulsions are present there is typically a discernible relationship between them in content or temporal sequence. Compulsions are most often performed in response to obsessions (e.g., excessive hand washing due to fear of contamination). However, in some individuals with Obsessive-Compulsive Disorder, particularly during the initial phase of the disorder, compulsions may precede the manifestation of obsessions. For example, an individual begins to feel that he must be afraid of an accidental fire because he repeatedly checks the gas knob on the stove or an individual concludes that she must be afraid of contamination based on the evidence of her repeated hand washing. Understanding the relationship between obsessions and compulsions can assist in intervention selection and treatment planning.

Boundary with Normality (Threshold):

- Intrusive thoughts, images, and impulses/urges as well as repetitive behaviours are common in the general population (e.g., thoughts of harming a loved one, double-checking that the door is locked). Obsessive-Compulsive Disorder should only be diagnosed when obsessions and compulsions are time-consuming (e.g., take more than 1 hour per day) or cause significant distress or result in functional impairment.

- Developmentally normative preoccupations (e.g., worrying about interacting with strangers in young children) and rituals (e.g., skipping over cracks in a sidewalk) should not be attributed to a presumptive diagnosis of Obsessive-Compulsive Disorder and are differentiated from obsessions and compulsions characteristic of Obsessive-Compulsive Disorder because they are transient, age-appropriate, not time-consuming (e.g., taking more than hour per day), and do not result in significant distress or impairment.

Course Features:

- Obsessive-Compulsive Disorder typically has an age of onset in the late teens and early twenties, with late onset (i.e., after age 35) being less common. In cases of late onset, there is often a history of chronic sub-clinical symptoms.
- Onset of Obsessive-Compulsive Disorder symptoms is often gradual. Sudden or late onset, in particular, should prompt additional assessment to differentiate Obsessive-Compulsive Disorder from other medical conditions (e.g., basal ganglia ischemic stroke) that may better explain the symptoms.
- Many adults with Obsessive-Compulsive Disorder (30%-50%) report a childhood onset of symptoms. For those with onset during childhood or adolescence, 40% may experience a remission of symptoms by early adulthood.
- Obsessive-Compulsive Disorder in adults is generally considered a chronic condition with waxing and waning of symptoms. Some experience an episodic course and a minority experience a worsening course.

Developmental Presentations:

- Onset before age 10 is more common among males (approximately 25%), whereas adolescent onset is more likely among females. Younger age of onset is associated with greater genetic loading and poorer outcomes due to interference of symptoms with achieving developmental milestones (e.g., forming peer relationships, acquiring academic skills). Although childhood-onset Obsessive-Compulsive Disorder typically follows a chronic course, particularly if left untreated, symptoms tend to wax and wane and many (approximately 40%) experience full remission by early adulthood. Among the elderly, the prevalence of Obsessive-Compulsive Disorder is slightly higher among men than women.
- Although precipitous onset of Obsessive-Compulsive Disorder symptoms in children and adolescents has been reported, often attributed to Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS), development of symptoms is typically gradual.
- The content and type of obsessions and compulsions varies across the lifespan. Children and adolescents are more likely to report obsessions centred upon bad things happening to their loved ones (e.g., parents) whereas adolescents and adults are more likely to report religious or sexual obsessions. Among children and adolescents, females are more likely to report symptoms centred upon contamination or cleaning whereas males are more like those of a sexual-religious or aggressive nature. It may be easier to assess for the presence of compulsions in children because their level of cognitive development may preclude verbalizing content of obsessions.
- Among children and adolescents, the course of Obsessive-Compulsive Disorder is frequently complicated by the co-occurrence of other mental disorders, the presence of

which may affect identification of Obsessive-Compulsive Disorder among youth. Up to 30% of all individuals with Obsessive-Compulsive Disorder will also experience Tourette Syndrome or another primary tic disorder during their lifetime. Co-occurring tics are more common among males with childhood-onset Obsessive-Compulsive Disorder. Children and adolescents are also more likely than adults to present with a combination of Obsessive-Compulsive Disorder, a primary tic disorder and/or Attention Deficit Hyperactivity Disorder. Body Dysmorphic Disorder or Hoarding Disorder often co-occur among adolescents with Obsessive-Compulsive Disorder. Approximately half of elderly patients with Obsessive-Compulsive Disorder exhibit ordering, hoarding and checking behaviours, which may also reflect symptoms of Personality Disorder with anankastic traits.

Culture-Related Features:

- Similar types of Obsessive-Compulsivity Disorder symptoms (e.g., concerns with contamination) are present cross-culturally, but cultural variation exists in the salience and prevalence of certain themes of content of obsessions and compulsions. For example, aggressive obsessions have been found to predominate in Brazil and religious/scrupulosity concerns in Middle Eastern settings. In addition, scrupulosity obsessions may be more distressing among individuals of certain faith groups that emphasize ritual exactitude or the sinful nature of certain kinds of thoughts. The influence of culture may lead to the adoption of specific themes, such as fear of contamination by HIV/AIDS, obsessions about *kashrut* (dietary restrictions) observances among Jews, or about being in a state of uncleanliness (*Napak*) among Muslims. Distinguishing religious compulsions from zealous but normative religious practice may require the help of religious experts aware of local norms.
- Etiological attributions may vary across social groups, including biological, psychological, social, and supernatural or spiritual explanations. These attributions may also shape the specific obsessions, such as concerns about being deserving of punishment as the result of a transgression or the object of sorcery, witchcraft, or the evil eye. In some cultural groups, compulsions may be reinforced by the belief that such acts ward off evil spirits or have another spiritual function.
- Help seeking and clinical disclosure are less likely when the obsessions or compulsions are considered by the individual to be culturally taboo.

Gender-Related Features:

- Males are more likely to experience Obsessive-Compulsive Disorder during childhood, with approximately 25% experiencing onset before age 10. During adulthood, prevalence is higher for females.
- Males are more likely to experience co-occurring primary tic disorders.
- Gender differences in the specific content of obsessions and compulsions have been reported whereby females are more likely to report cleaning and contamination related themes and males are more likely to report symmetry related themes and taboo intrusive thoughts (e.g., violent impulses, sacrilegious images).
- Onset or exacerbation of Obsessive-Compulsive Disorder has been reported during the peripartum period.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Hypochondriasis (Health Anxiety Disorder):*** Hypochondriasis is characterized by persistent preoccupation or fear about the possibility of having one or more serious, progressive or life-threatening illnesses. Although obsessions in Obsessive-Compulsive Disorder may be health-related, when these occur they tend to be focused more on potential contamination than on the undiagnosed symptoms of a particular illness and to be accompanied by a history of other obsessions that are not health-related.
- ***Boundary with other Obsessive-Compulsive or Related Disorders:*** Recurrent thoughts and repetitive behaviours occur in other Obsessive-Compulsive or Related Disorders but the foci of apprehension and form of repetitive behaviours are distinct for each diagnostic entity. In Body Dysmorphic Disorder, the intrusive thoughts and repetitive behaviours are limited to concerns about physical appearance. In Trichotillomania or Excoriation Disorder, the repetitive behaviours are limited to hair pulling or skin picking, respectively, in the absence of obsessions. Hoarding Disorder symptoms include excessive accumulation or difficulty discarding possessions and marked distress related to discarding items. Hoarding behaviour can be symptomatic of Obsessive-Compulsive Disorder, but in contrast to Hoarding Disorder it is undertaken with the goal of neutralizing or reducing concomitant distress and anxiety arising from obsessional content such as aggressive (e.g., fear of harming others), sexual/religious (e.g., fear of committing blasphemous or disrespectful acts), contamination (e.g., fear of spreading infectious diseases), or symmetry/ordering (e.g., feeling of incompleteness) themes. However, Obsessive-Compulsive or Related Disorders can co-occur, and multiple diagnoses from this grouping may be assigned if warranted.
- ***Boundary with Autism Spectrum Disorder:*** Persistent repetitive thoughts, images, or impulses/urges (i.e., obsessions) and/or repetitive behaviours (i.e., compulsions) characteristic of Obsessive-Compulsive Disorder may be difficult to distinguish from restricted, repetitive, and inflexible patterns of behaviour, interests, or activities that are characteristic of Autism Spectrum Disorder. However, unlike those with Autism Spectrum Disorder, individuals with Obsessive-Compulsive Disorder feel driven to perform repetitive behaviours in response to an obsession, according to rigid rules, to reduce anxiety, or to achieve a sense of 'completeness'. Obsessive-Compulsive Disorder can also be distinguished from Autism Spectrum Disorder because difficulties in initiating and sustaining social communication and reciprocal social interactions are not features of Obsessive-Compulsive Disorder.
- ***Boundary with Stereotyped Movement Disorder:*** A stereotyped movement is a repetitive, seemingly driven non-functional motor behaviour (e.g., head banging, body rocking, self-biting). These movements are typically less complex than compulsions and are not aimed at neutralizing obsessions.
- ***Boundary with Delusional Disorder and other Primary Psychotic Disorders:*** Some individuals with Obsessive-Compulsive Disorder lack insight about the irrationality of their thoughts and behaviours to such an extent that convictions of the veracity of their obsessions as well as the strength of beliefs regarding the connection between compulsions and obsessions may at times appear to be delusional in the degree of conviction and fixity with which these beliefs are held (see Insight qualifiers, page __). If these beliefs are restricted to fear or conviction that intrusive thoughts, images, or impulses/urges are true or that compulsions are realistically connected to obsessional

content in an individual without a history of other delusions, that is, these beliefs occur entirely in the context of symptomatic episodes of Obsessive-Compulsive Disorder and are fully consistent with the other clinical features of the disorder, Obsessive-Compulsive Disorder should be diagnosed instead of Delusional Disorder. Individuals with Obsessive-Compulsive Disorder do not exhibit other features of psychosis (e.g., hallucinations or formal thought disorder).

- ***Boundary with Depressive Disorders:*** Differentiating rumination that occurs in the context of Depressive Disorders from obsessions and compulsive mental acts characteristic of Obsessive-Compulsive Disorder is challenging. Nonetheless, it may be helpful to consider that ruminations are typically congruent with negative affect and reflect depressive cognition (e.g., self-criticism, guilt, failure, regret, pessimism, hopelessness). Unlike obsessions, ruminations are not typically experienced as intrusive, nor are they linked to compulsive behaviours. In contrast to ruminations, compulsive mental acts are typically performed with the intention of reducing distress or perceived risk of harm. Individuals with Depressive Disorders experience low mood or a lack of interest in pleasurable activities, which are not diagnostic features of Obsessive-Compulsive Disorder. However, Obsessive-Compulsive Disorder and Depressive Disorders often co-occur, and both diagnoses may be assigned if the full diagnostic requirements are met.
- ***Boundary with Anxiety or Fear-Related Disorders:*** Recurrent thoughts, avoidance behaviours, and requests for reassurance commonly observed in Obsessive-Compulsive Disorder also occur in Anxiety or Fear-Related Disorders. In contrast to Anxiety or Fear-Related Disorders, however, obsessions in Obsessive-Compulsive Disorder are experienced as intrusive, can involve content that is odd or irrational (e.g., intrusive images of harming a friend), and are typically accompanied by compulsions. Obsessive-Compulsive Disorder is further differentiated by not being characterized by the same foci of apprehension that characterize Anxiety or Fear-Related Disorders. For example, in Generalized Anxiety Disorder, the recurrent thoughts or worries are focused on negative events that could possibly occur in different aspects of everyday life (e.g., work, finances, health, family). In Social Anxiety Disorder, symptoms are in response to feared social situations (e.g., speaking in public, initiating a conversation) and concerns about being negatively evaluated by others. In Specific Phobia, symptoms are limited to one or a few circumscribed phobic objects or situations (e.g., fear and avoidance of animals) and concerns are about the perceived harm that could arise if exposed to these stimuli (e.g., being bitten by an animal).
- ***Boundary with Panic Disorder:*** Panic Disorder is characterized by recurrent, unexpected panic attacks. Some individuals with Obsessive-Compulsive Disorder experience panic attacks that are triggered by feared stimuli associated with obsessions and compulsions or if the individual is prevented from enacting neutralizing compulsions. If an individual with Obsessive-Compulsive Disorder experiences panic attacks exclusively in relation to obsessions or compulsions without the presence of unexpected panic attacks, an additional diagnosis of Panic Disorder is not warranted. However, unexpected panic attacks are also present and all other diagnostic requirements are met, both diagnoses may be assigned.
- ***Boundary with Post-Traumatic Stress Disorder:*** In Post-Traumatic Stress Disorder, symptoms are limited to stimuli associated with or that serve as reminders of a traumatic event (e.g., fear and avoidance of a place where an individual was assaulted) and the intrusive thoughts and images are associated with the traumatic event.

- ***Boundary with Eating Disorders:*** Obsessive-Compulsive Disorder can be distinguished from Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder because obsessions and compulsions are not limited to concerns about being or becoming overweight and are not accompanied by body image distortions.
- ***Boundary with Disorders Due to Substance Use and Impulse Control Disorders:*** A variety of behaviours may be described by lay people and sometimes by health professionals as 'compulsive', including sexual behaviour, gambling, and substance use. Compulsions characteristic of Obsessive-Compulsive Disorder, are differentiated from these behaviours in that they typically lack a rational motivation and are rarely reported to be pleasurable, though they may reduce anxiety or distress. Behaviours such as sexual behaviour, gambling, and substance abuse are also not typically preceded by intrusive unwanted thoughts characteristic of obsessions, although they are often preceded by thoughts about engaging in the relevant behaviour.
- ***Boundary with Primary Tics or Tic Disorders including Tourette Syndrome:*** A tic is a sudden, rapid, recurrent, non-rhythmic motor movement or vocalization (e.g., eye blinking, throat clearing). Obsessive-Compulsive Disorder can be differentiated from Tic Disorders because unlike compulsions, tics appear unintentional in nature and clearly utilize a discrete muscle group. However, it can be difficult to distinguish between complex tics and compulsions associated with Obsessive-Compulsive Disorder. Although tics (both complex and simple) are preceded by premonitory sensory urges, which diminish as tics occur, tics are not aimed at neutralizing antecedent cognitions (e.g., obsessions) or reducing anxiety. Many individuals exhibit symptoms of both Obsessive-Compulsive Disorder and primary tic disorders, in particular, Tourette Syndrome, and both diagnoses may be assigned if the diagnostic requirements for each are met.
- ***Boundary with Personality Disorder with prominent anankastic features:*** Personality Disorder with prominent anankastic features involves an enduring and pervasive maladaptive pattern of excessive perfectionism and rigid control. Individuals with Personality Disorder with prominent anankastic features do not experience intrusive thoughts, images, or impulses/urges characteristic of Obsessive-Compulsive Disorder or engage in repetitive behaviours response to these intrusive thoughts. If diagnostic requirements for both Obsessive-Compulsive Disorder and a Personality Disorder with prominent anankastic features are met, both diagnoses may be assigned.

6B21 Body Dysmorphic Disorder

Essential (Required) Features:

- Persistent preoccupation with one or more perceived defects or flaws in appearance, or ugliness in general, that is either unnoticeable or only slightly noticeable to others.
- Excessive self-consciousness about the perceived defect(s) or flaw(s), often including ideas of self-reference [i.e., the conviction that people are taking notice, judging, or talking about the perceived defect(s) or flaw(s)].
- The preoccupation or self-consciousness is accompanied by any of the following:
    - Repetitive and excessive behaviours, such as repeated examination of the appearance or severity of the perceived defect(s) or flaw(s) (e.g., by checking in reflective surfaces) or comparison of the relevant feature with that of others;

  - Excessive attempts to camouflage or alter the perceived defect (e.g., specific and elaborate forms of dress, undergoing ill-advised cosmetic surgical procedures);
  - Marked avoidance of social or other situations or stimuli that increase distress about the perceived defect(s) or flaw(s) (e.g., reflective surfaces, changing rooms, swimming pools).
- The symptoms are not a manifestation of another medical condition and are not due to the effect of a substance or medication on the central nervous system, including withdrawal effects.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Insight qualifiers:

Individuals with Body Dysmorphic Disorder vary in the degree of insight they have about the accuracy of the beliefs that underlie their symptoms. Although many can acknowledge that their thoughts or behaviours are untrue or excessive, some cannot, and the beliefs of some individuals with Body Dysmorphic Disorder may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (e.g., an individual is convinced that others think he is hideously ugly). Insight may vary substantially even over short periods of time, for example depending on the level of current anxiety or distress, and should be assessed with respect to a time period that is sufficient to allow for such fluctuation (e.g., a few days or a week). The degree of insight that an individual exhibits in the context of Body Dysmorphic Disorder can be specified as follows:

6B21.0 Body Dysmorphic Disorder with fair to good insight

- Much of the time, the individual is able to entertain the possibility that their disorder-specific beliefs may not be true and they are willing to accept an alternative explanation for their experience. This qualifier level may still be applied if, at circumscribed times (e.g., when highly anxious), the individual demonstrates no insight.

6B21.1 Body Dysmorphic Disorder with poor to absent insight

- Most or all of the time, the individual is convinced that the disorder-specific beliefs are true and they cannot accept an alternative explanation for their experience. The lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.

Additional Clinical Features:

- Any part of the body may be the focus of the perceived flaw(s) or defect(s), but the most common area is the face (especially the skin, nose, hair, eyes, teeth, lips, chin, or overall facial appearance). However, there are frequently multiple perceived defects. Usually the focal feature is regarded as flawed, defective, asymmetrical, too big/small or disproportionate, or the complaint may be of thinning hair, acne, wrinkles, scars,

vascular markings, pallor or ruddiness of complexion, or insufficient muscularity. Sometimes the preoccupation is vague or consists of a general perception of ugliness or being 'not right' or being too masculine/feminine.

- Muscle dysmorphia, a form of Body Dysmorphic Disorder, can place affected individuals, usually males, at increased risk for complications requiring medical attention (e.g., muscle tears, strains, side effects of steroid use).
- There is a high risk of suicide in adolescents and adults with Body Dysmorphic Disorder, particularly when depressive symptomatology co-occurs. Due to the low base rate occurrence of attempted and completed suicide, it is difficult to predict suicidal behaviours. Factors to consider in assessing risk include previous attempts, lack of perceived psychosocial supports, perception of burdensomeness, and hopelessness. It is also important to consider that identification of Body Dysmorphic Disorder may be especially challenging because the increased occurrence of shame and perceived stigma among affected individuals often leads them to conceal their difficulties or present with symptoms of Depressive Disorders, Social Anxiety Disorder, or Obsessive-Compulsive Disorder rather than Body Dysmorphic Disorder.
- The diagnosis of Body Dysmorphic Disorder is typically made based on direct observation or physical examination of the perceived body flaw(s) or defect(s). If this is not possible because it is inappropriate or the individual refuses to remove their camouflage, then it may be difficult to make a judgment about how noticeable or abnormal a perceived defect is. In such cases corroborative evidence may be required from a knowledgeable informant or physician who has conducted a physical examination of the individual.
- In some cases, individuals may be persistently preoccupied with one or more perceived defects or flaws in appearance, or ugliness in general, of another person, generally a child or a romantic partner, that is either unnoticeable or only slightly noticeable to others. This phenomenon is often referred to as Body Dysmorphic Disorder by proxy. If the other diagnostic requirements for the disorder are met with reference to the perceived bodily flaw(s) or defect(s) of the other person (e.g., excessive self-consciousness, repetitive and excessive examination or checking, marked camouflaging or alteration of the perceived defect, avoidance of relevant social situations or triggers, distress or functional impairment), a diagnosis of Body Dysmorphic Disorder may be assigned to the individual experiencing the preoccupation.

Boundary with Normality (Threshold):

- Body image concerns are common in many cultures, especially during adolescence. Body Dysmorphic Disorder is differentiated from body dissatisfaction or body image concerns by the degree of preoccupation, frequency of related recurrent behaviours performed, as well as the degree of distress or interference the individual experiences as a consequence of these symptoms.

Course Features:

- The onset of Body Dysmorphic Disorder commonly occurs during adolescence with two thirds of individuals reporting onset before age 18. Subclinical symptoms may appear during early adolescence (at 12 or 13 years of age).

- Although the typical course of Body Dysmorphic Disorder involves a gradual worsening of symptoms from subclinical to full symptomatic presentation, some individuals may experience an acute onset of symptoms.
- Among individuals with onset before age 18, Body Dysmorphic Disorder is associated with gradual onset of symptoms and co-occurring disorders. These individuals are also at greater risk of attempting suicide.
- Body Dysmorphic Disorder is generally considered a chronic disorder.

Developmental Presentations:

- Notwithstanding a relatively early age of onset of Body Dysmorphic Disorder, it typically takes 10-15 years before affected individuals seek help. New onset may occur among the elderly, though research with this age group is very limited.
- Onset of Body Dysmorphic Disorder symptoms tends to be gradual. The disorder is recurrent, chronic, and likely to persist without intervention.
- Prevalence of Body Dysmorphic Disorder among adolescents is estimated at approximately 2%, with higher prevalence among female adolescents. Prevalence rates are likely an underestimate because shame, embarrassment and stigma about symptoms frequently interfere with help-seeking behaviours.
- Symptom presentation is similar across all age groups. However, differentiating between normality and Body Dysmorphic Disorder in adolescence may be complicated by the emergence of developmentally-normative concerns about body image that occur during this stage.
- The course and severity of the disorder tends to be worse among individuals with an earlier onset (prior to age 18). Specifically, these individuals are at increased risk for suicide, present with more co-occurring mental disorders, have poorer insight, and are more likely to have experienced a gradual progression of symptom onset than individuals who develop Body Dysmorphic Disorder in adulthood. Youth with Body Dysmorphic Disorder are also at increased risk for school drop-out, potentially impacting their academic and social development.

Culture-Related Features:

- The symptoms of Body Dysmorphic Disorder are similar across cultures, but specific concerns are shaped by cultural standards regarding what is considered attractive, acceptable, normal, or desired. For example, populations in East Asia might be focused on epicanthal folds and concerns about skin colour may be associated with racialized conceptions of desirable body characteristics.
- Within more collectivistic cultures, or cultures that emphasize shame, the nature of the concern about bodily deformities may be focused on anxiety about causing offense to others.
- There are cultural concepts of distress that focus on perceptions of abnormal bodily features and may shape the symptoms of Body Dysmorphic Disorder. For example, the *shubo-kyofu* (“fear of a deformed body”) subtype of *taijin kyofusho* has been reported primarily in Japan; it is characterized by intense fear of offending, embarrassing or hurting others through the person’s appearance, which is perceived as deformed. Insight is typically poor to absent.

Gender-Related Features:

- Although prevalence rates are similar for both genders, differences in presentation have been described. Women are more likely to experience co-occurring Eating Disorders; whereas men are more likely to be concerned with the appearance of their genitalia and their overall physique (i.e., muscle dysmorphia).

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Hypochondriasis (Health Anxiety Disorder):*** Hypochondriasis is characterized by persistent preoccupation or fear about the possibility of having one or more serious, progressive or life-threatening illnesses, whereas in Body Dysmorphic Disorder the preoccupation is with perceived flaws or defects in the individual's appearance.
- ***Boundary with Trichotillomania (Hair Pulling Disorder) and Excoriation (Skin Picking) Disorder:*** Skin picking and hair pulling can occur as symptoms of Body Dysmorphic Disorder when there is a preoccupation with the skin or hair appearing defective and the intended aim is to improve its appearance. In contrast, when the behaviour is a body-focused repetitive behaviour with no clear relationship to a perceived defect on the skin or hair, then it is better classified as Trichotillomania or Excoriation Disorder.
- ***Boundary with other Obsessive-Compulsive or Related Disorders:*** Recurrent thoughts and repetitive behaviours occur in other Obsessive-Compulsive or Related Disorders but the foci of apprehension and form of repetitive behaviours are distinct for each diagnostic entity. In Obsessive-Compulsive Disorder, the intrusive thoughts and repetitive behaviours are not limited to concerns about appearance but rather encompass a variety of obsessions (e.g., of contamination, of causing harm) and compulsions (e.g., excessive washing, counting, checking) intended to neutralize these obsessions. In Olfactory Reference Disorder individuals are preoccupied exclusively with emitting a perceived foul or offensive body odour. However, Obsessive-Compulsive or Related Disorders can co-occur, and multiple diagnoses from this grouping may be assigned if warranted.
- ***Boundary with Delusional Disorder and other Primary Psychotic Disorders:*** Many individuals with Body Dysmorphic Disorder lack insight about the irrationality of their thoughts and behaviours to such an extent that convictions that their appearance is flawed may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (see Insight qualifiers, page __). If these beliefs are restricted to the fear or conviction of having a flawed appearance or bodily defect in an individual without a history of other delusions, that is, these beliefs occur entirely in the context of symptomatic episodes of Body Dysmorphic Disorder and are fully consistent with the other clinical features of the disorder, Body Dysmorphic Disorder should be diagnosed instead of Delusional Disorder. Individuals with Body Dysmorphic Disorder do not exhibit other features of psychosis (e.g., hallucinations or formal thought disorder).
- ***Boundary with Mood Disorders:*** Individuals experiencing a Depressive Episode with psychotic symptoms may occasionally become preoccupied with perceived physical flaws or defects, which can be differentiated from Body Dysmorphic Disorder on the basis of the absence of such symptoms outside of the Mood Episode. However,

individuals with a history of Body Dysmorphic Disorder commonly experience co-occurring depressive symptoms as a consequence of the distress and impairment of their Body Dysmorphic Disorder symptoms. If depressive symptoms consistent with a Mood Disorder are present in an individual with Body Dysmorphic Disorder, both disorders may be diagnosed.

- ***Boundary with Generalized Anxiety Disorder:*** In Generalized Anxiety Disorder, recurrent thoughts or worries are focused on potential negative outcomes that might occur in a variety of everyday aspects of life (e.g., family, finances, work). Although some individuals with Generalized Anxiety Disorder may worry excessively about their appearance, these preoccupations occur together with worries about other aspects of life, are rarely delusional, and are not typically accompanied by the recurrent checking behaviour associated with Body Dysmorphic Disorder.
- ***Boundary with Social Anxiety Disorder:*** In Social Anxiety Disorder, symptoms are in response to feared social situations and the primary concern is about the person's own behaviour or manifestations of anxiety (e.g., fear they may blush) being negatively evaluated by others. In contrast, individuals with Body Dysmorphic Disorder believe their appearance or a specific feature of their appearance (e.g., belief that skin appears permanently red) looks flawed. Some individuals with Body Dysmorphic Disorder experience significant anxiety in social situations and fear they will be seen as ugly and therefore be rejected. If their concerns are broader than the exclusive focus on their perceived flaws or defects in appearance and other symptoms of Social Anxiety Disorder are present, both conditions may be diagnosed.
- ***Boundary with Eating Disorders:*** Body Dysmorphic Disorder can be distinguished from Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder because preoccupations in Body Dysmorphic Disorder are not limited to body image concerns (i.e., idealized low body weight). Rather, the preoccupations can encompass a variety of idealized aspects of appearance. Some individuals with Body Dysmorphic Disorder exhibit muscle dysmorphia such that they are preoccupied about being insufficiently muscular or lean and in response, may exhibit unusual eating behaviours (e.g., excessive protein consumption) or engage in excessive exercise (e.g., weight lifting). In these cases, behaviours related to diet and exercise are motivated by a desire to be more muscular rather than to attain or maintain a low body weight. However, if low body weight idealization is central to the clinical presentation and all other diagnostic requirements are met, a diagnosis of Anorexia Nervosa instead of Body Dysmorphic Disorder should be assigned.
- ***Boundary with Body Integrity Dysphoria:*** The persistent preoccupation and excessive self-consciousness experienced by individuals with Body Dysmorphic Disorder derives from their concerns that an aspect of their body or appearance is perceived by others to be ugly or deformed. In contrast, the persistent discomfort or intense negative feelings about a particular body part (most commonly one or both arms or legs) experienced by individuals with the rare condition of Body Integrity Dysphoria derives from their sense that a part of their body is alien or the way their body is configured is wrong or unnatural. This leads to a desire to amputate or be rid of the particular body part, rather than wishing to improve its appearance.
- ***Boundary with Gender Incongruence of Adolescence and Adulthood and Gender Incongruence of Childhood:*** Gender Incongruence of Adolescence and Adulthood as well as Gender Incongruence of Childhood differ from Body Dysmorphic Disorder in that in these conditions the preoccupation with aspects of bodily appearance centres

exclusively on the individual's experience of a marked incongruence between their expressed or experienced gender and their biological sex. A common consequence is that individuals will clearly state a desire to alter their primary and secondary sex characteristics such that they align with their experienced gender.

6B22 Olfactory Reference Disorder

Essential (Required) Features:

- Persistent preoccupation about emitting a foul or offensive body odour or breath (i.e., halitosis) that is either unnoticeable or slightly noticeable to others such that the individual's concerns are markedly disproportionate to the smell, if any is perceptible.
- Excessive self-consciousness about the perceived odour, often including ideas of self-reference (i.e., the conviction that people are taking notice, judging, or talking about the odour).
- The preoccupation or self-consciousness is accompanied by any of the following:
    - Repetitive and excessive behaviours, such as repeatedly checking for body odour or checking the perceived source of the smell (e.g., clothing), or repeatedly seeking reassurance;
    - Excessive attempts to camouflage, alter, or prevent the perceived odour (e.g., using perfume or deodorant, repetitive bathing, brushing teeth, or changing clothing, avoidance of certain foods);
    - Marked avoidance of social or other situations or stimuli that increase distress about the perceived foul or offensive odour (e.g., public transportation or other situations of close proximity to other people).
- The symptoms are not a manifestation of another medical condition and are not due to the effect of a substance or medication on the central nervous system, including withdrawal effects.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Insight qualifiers:

Individuals with Olfactory Reference Disorder vary in the degree of insight they have about the accuracy of the beliefs that underlie their symptoms. Although many can acknowledge that their thoughts or behaviours are untrue or excessive, some cannot, and the beliefs of some individuals with Olfactory Reference Disorder may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (e.g., an individual is convinced that she is emitting a foul odour). Insight may vary substantially even over short periods of time, for example depending on the level of current anxiety or distress, and should be assessed with respect to a time period that is sufficient to allow for such fluctuation (e.g., a few days or a week). The degree of insight that an individual exhibits in the context of Olfactory Reference Disorder can be specified as follows:

6B22.0 Olfactory Reference Disorder with fair to good insight

- Much of the time, the individual is able to entertain the possibility that their disorder-specific beliefs may not be true and they are willing to accept an alternative explanation for their experience. This qualifier level may still be applied if, at circumscribed times (e.g., when highly anxious), the individual demonstrates no insight.

6B22.1 Olfactory Reference Disorder with poor to absent insight

- Most or all of the time, the individual is convinced that the disorder-specific beliefs are true and they cannot accept an alternative explanation for their experience. The lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.

Additional Clinical Features:

- The diagnosis of Olfactory Reference Disorder partly depends on determining whether there is evidence of the odour reported by the individual. A variety of other medical and dental conditions can be associated with unpleasant odours (e.g., periodontal disease, trimethylaminuria), and these underlying causes should be ruled out, particularly if the odour is detectable even if slight. However, the perceived odour may vary in intensity or the individual may be unable or unwilling to remove camouflaging odours (e.g., perfume), which may make it difficult to judge how noticeable the odour is. In such cases corroborative evidence may be required from a knowledgeable informant or physician who has conducted a physical examination of the individual.

Boundary with Normality (Threshold):

- Fear of emitting offensive odours is, to some extent, common in many cultures. However Olfactory Reference Disorder can be differentiated from normal concerns by the degree of preoccupation, frequency of related recurrent behaviours performed, as well as the degree of distress or interference the individual experiences as a consequence of these symptoms.

Course Features:

- Onset of Olfactory Reference Disorder is most often reported as occurring during the mid-twenties; however, onset during puberty or adolescence is also common.
- Olfactory Reference Disorder is generally considered a chronic and persistent disorder with a potential worsening over time.
- Embarrassment and shame, in conjunction with limited insight and false beliefs that may be delusional in intensity, may lead to underreporting of concerns related to perceived body odour in clinical settings.
- Individuals with Olfactory Reference Disorders often consult non-mental health services on multiple occasions (i.e., medical, surgical, dental specialists) about their perceived odour prior to receiving a diagnosis.

Developmental Presentations:

- Developmentally distinct presentations of Olfactory Reference Disorder for children, adolescents, or older adults have not been reported.

Culture-Related Features:

- Within more collectivistic cultures, or cultures that emphasize shame, the nature of the concern about bodily odour may be focused around fears of causing offense to others.
- Cultural concepts related to Olfactory Reference Disorder include *taijin kyofusho* in Japan and related conditions in Korea and other societies. They are characterized by intense fear of offending, embarrassing or hurting others through improper or awkward social behaviour, movements, or appearance. If the concerns focus specifically on body odour, Olfactory Reference Disorder is the appropriate ICD-11 diagnosis. In these cases, insight is typically poor to absent.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Obsessive-Compulsive Disorder:*** Recurrent thoughts and repetitive behaviours occur in Obsessive-Compulsive Disorder. However, in Olfactory Reference Disorder, the intrusive thoughts and repetitive behaviours are limited to concerns about body or breath odour. If obsessive thoughts and compulsive behaviours are not restricted to concerns about emitting a smell, both disorders can be diagnosed.
- ***Boundary with Delusional Disorder and other Primary Psychotic Disorders:*** Many individuals with Olfactory Reference Disorder lack insight about the irrationality of their thoughts and behaviours to such an extent that convictions that they are emitting a foul odour may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (see Insight qualifiers, page __). If these beliefs are restricted to the fear or conviction of emitting a foul odour in an individual without a history of other delusions, that is, these beliefs occur entirely in the context of symptomatic episodes of Olfactory Reference Disorder and are fully consistent with the other clinical features or the disorder, Olfactory Reference Disorder should be diagnosed instead of Delusional Disorder. Individuals with Olfactory Reference Disorder do not exhibit other features of psychosis (e.g., hallucinations or formal thought disorder).
- ***Boundary with Mood Disorders:*** In Depressive Disorders with psychotic symptoms, somatic delusions related to a perceived odour can occur (e.g., that their flesh is rotting and smells fetid), but typically are an integral part of a range of preoccupations or delusions (e.g., related to guilt, nihilism, poverty, etc.) and occur alongside other depressive symptoms (e.g., loss of interest in pleasurable activities, suicidality, sleep disturbances, weight loss or gain, etc.). However, both disorders may co-occur and both diagnoses may be assigned if warranted.
- ***Boundary with Social Anxiety Disorder:*** Individuals with Olfactory Reference Disorder may avoid social situations specifically because they believe they are emitting a foul odour. In contrast, in Social Anxiety Disorder, social situations are avoided because the individual is concerned that he or she will act in a way, or show anxiety symptoms, that will be negatively evaluated by others (i.e., be humiliating, embarrassing, lead to rejection, or be offensive).

6B23 Hypochondriasis (Health Anxiety Disorder)

Essential (Required) Features:

- Persistent preoccupation or fear about the possibility of having one or more serious, progressive or life-threatening illnesses.
- The preoccupation is accompanied by either:
  - Repetitive and excessive health-related behaviours, such as repeatedly checking of the body for evidence of illness, spending inordinate amounts of time searching for information about the feared illness, repeatedly seeking reassurance (e.g., arranging multiple medical consultations); or
  - Maladaptive avoidance behaviour related to health (e.g., avoids medical appointments).
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Insight qualifiers:

Individuals with Hypochondriasis vary in the degree of insight they have about the accuracy of the beliefs that underlie their health concerns. Although many can acknowledge that their thoughts or behaviours are untrue or excessive, some cannot, and the beliefs of a small minority of individuals with Hypochondriasis may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (e.g., an individual is convinced that he has a terminal illness). Insight may vary substantially even over short periods of time, for example depending on the level of current anxiety or distress, and should be assessed with respect to a time period that is sufficient to allow for such fluctuation (e.g., a few days or a week). The degree of insight that an individual exhibits in the context of Hypochondriasis can be specified as follows:

6B23.0 Hypochondriasis with fair to good insight

- Much of the time, the individual is able to entertain the possibility that their disorder-specific beliefs may not be true and they are willing to accept an alternative explanation for their experience. This qualifier level may still be applied if, at circumscribed times (e.g., when highly anxious), the individual demonstrates no insight.

6B23.1 Hypochondriasis with poor to absent insight

- Most or all of the time, the individual is convinced that the disorder-specific beliefs are true and they cannot accept an alternative explanation for their experience. The lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.

Additional Clinical Features:

- Individuals with Hypochondriasis often make catastrophic misinterpretations of bodily signs or symptoms, including normal or commonplace sensations (e.g., worrying that a tension headache is indicative of a brain tumour).
- Individuals with Hypochondriasis typically have a high level of anxiety about health, are often hypervigilant of bodily sensations and symptoms, and may become easily alarmed about their personal health status, to the extent that the experience of anxiety, including panic attacks, may be a significant presenting feature. For this reason, Health Anxiety Disorder is included as an alternate name for the disorder.
- Individuals with Hypochondriasis may undergo repeated, unnecessary, medical examinations and diagnostic tests, with deterioration of the clinician-individual relationship, and frequent 'doctor-shopping'. They may also spend excessive time searching health and medical sites on the internet.
- Conversely, individuals with Hypochondriasis may respond to their anxiety about their health by avoiding contact with reminders of health status, including medical check-ups, health facilities, and health-related information.
- Individuals with Hypochondriasis may become alarmed about their health when someone they know becomes sick, when they read or hear about illness, or in response to life stressors. The preoccupation is often a central topic of their conversation with others.

Boundary with Normality (Threshold):

- The preoccupation is not simply a reasonable concern related to a circumscribed situation (e.g., awaiting results of testing for a serious illness) and persists or reoccurs despite appropriate medical evaluation and reassurance.
- If a chronic or acute medical condition is present, or the individual is at high risk for developing a medical condition (e.g., due to high genetic risk, a recent exposure to a communicable disease), preoccupations related to such conditions are common and a high threshold should be used for a diagnosis of Hypochondriasis. The diagnosis of Hypochondriasis should only be made if the degree of preoccupation and repetitive health-related behaviours or avoidance are clearly excessive and disproportionate.
- Health-related anxiety is common among the elderly. New onset of health concerns in later-life may reflect normal age-related concerns or, if excessive and impairing, the presence of a Depressive Disorder rather than Hypochondriasis.

Course Features:

- Hypochondriasis (Health Anxiety Disorder) is generally considered to be a chronic and relapsing condition leading to significant impairment.
- Individuals with Hypochondriasis are much more likely to seek medical services for somatic rather than mental health reasons, which often contributes to health-related anxiety due to the waiting for diagnostic testing or the belief that their concerns are not being taken seriously.

Developmental Presentations

- Hypochondriasis (Health Anxiety Disorder) tends to have its onset in early to mid-adulthood. Identification is often delayed because patients seek multiple consultations with health providers focusing on having a serious physical illness.
- Hypochondriasis is thought to be rare in childhood and adolescence. However, fears and beliefs focusing on health may emerge in early childhood with significant levels of symptoms persisting throughout childhood, potentially contributing to diagnostic requirements being met in adulthood.
- Hypochondriasis is common among the elderly—though often under-diagnosed—with symptoms frequently focusing on memory loss. Clinicians may fail to identify Hypochondriasis due to the presence of comorbid medical conditions that emerge with aging and/or co-occurrence with depressive symptoms that overshadow hypochondriacal concerns. Preoccupations with bodily concerns increases with age such that determining the degree to which these concerns are manifestations of depressive symptoms, physical conditions, an accurate reflection of declining bodily functioning, or Hypochondriasis is challenging.
- Among younger children, differential diagnosis between Hypochondriasis and Obsessive-Compulsive Disorder is particularly challenging because health concerns can be prominent features of both disorders. Children may not be able to articulate the content of their fears or the focus of their apprehension making it is difficult to assess the difference between symptoms of Hypochondriasis and Obsessive-Compulsive Disorder.

Culture-Related Features:

- In Hypochondriasis (Health Anxiety Disorder), the focus of illness belief or conviction may be influenced by cultural beliefs about how the illness might have been acquired. For example, in some cultures, Hypochondriasis might arise as a result of perceived failure to follow prescribed cultural practices or rituals or as the effect of a curse, witchcraft or sorcery.

Gender-Related Features:

- There are no known differences in prevalence rates between genders for Hypochondriasis.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Body Dysmorphic Disorder:*** Body Dysmorphic Disorder is characterized by persistent preoccupation with perceived flaws or defects in the individual's appearance, whereas in Hypochondriasis the preoccupation is about the possibility of having one or more serious, progressive or life-threatening illnesses.
- ***Boundary with other Obsessive-Compulsive or Related Disorders:*** Recurrent thoughts and repetitive behaviours occur in other Obsessive-Compulsive or Related Disorders but the foci of apprehension and form of repetitive behaviours are distinct for each diagnostic entity. In Obsessive-Compulsive Disorder, the intrusive thoughts and repetitive behaviours are not limited to concerns about health but rather encompass a variety of obsessions (e.g., of contamination, of causing harm) and compulsions (e.g., excessive washing, counting, checking) intended to neutralize these obsessions. In Body

Dysmorphic Disorder, the preoccupation is with perceived flaws in appearance or physical feature(s), whereas in Olfactory Reference Disorder, individuals are preoccupied exclusively with emitting a perceived foul or offensive body odour. However, Obsessive-Compulsive or Related Disorder can co-occur, and multiple diagnoses from this grouping may be assigned if warranted.

- ***Boundary with Delusional Disorder and other Primary Psychotic Disorders:*** Some individuals with Hypochondriasis lack insight about the irrationality of their thoughts and behaviours to such an extent that convictions of having a medical illness may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (see Insight qualifiers, page __). If these beliefs are restricted to the fear or conviction of having a disease in an individual without a history of other delusions, that is, these beliefs occur entirely in the context of symptomatic episodes of Hypochondriasis and are fully consistent with the other clinical features of the disorder, Hypochondriasis should be diagnosed instead of Delusional Disorder. Somatic delusions characteristic of some presentations of Delusional Disorder tend to be less medically plausible (e.g., that an organ is rotting) and are generally not focused on the belief that one has a specific disease. Individuals with Hypochondriasis do not exhibit other features of psychosis (e.g., hallucinations or formal thought disorder).
- ***Boundary with Depressive Disorders:*** In Depressive Disorders, hypochondriacal preoccupations or somatic delusions can occur, but typically are an integral part of a range of preoccupations or delusions (e.g., related to guilt, nihilism, poverty, etc.) and occur alongside other depressive symptoms (e.g., loss of interest in pleasurable activities, suicidality, sleep disturbances, weight loss or gain, etc.).
- ***Boundary with Generalized Anxiety Disorder:*** Individuals with Generalized Anxiety Disorder may have worries about their health, but they also harbour a range of other worries focused on negative events that could occur in several different aspects of everyday life (e.g., work, finances, health, family), and unlike Hypochondriasis there is typically not a persistent preoccupation with illness that persists despite medical evaluation and reassurance.
- ***Boundary with Panic Disorder:*** Panic Disorder is characterized by recurrent, unexpected panic attacks. Individuals with Panic Disorder often worry that the somatic symptoms they experience during panic attacks are evidence of serious medical condition (e.g., a heart attack or a stroke). An additional diagnosis of Hypochondriasis should not be assigned on that basis. Conversely, if an individual with Hypochondriasis experiences panic attacks exclusively in response to preoccupation or fear about the possibility of having one or more serious, progressive or life-threatening illnesses, an additional diagnosis of Panic Disorder is not warranted. However, if both unexpected panic attacks and persistent preoccupation or fear about the possibility of having one or more serious, progressive or life-threatening illnesses are present and all other diagnostic requirements are met, both diagnoses may be assigned.
- ***Boundary with Bodily Distress Disorder:*** Bodily Distress Disorder is characterized by the presence of bodily symptoms that are distressing to the individual and to which excessive attention is directed, such as dwelling on the severity of the symptoms and repeatedly visiting health care providers. While some individuals with Hypochondriasis may experience bodily symptoms that cause distress and for which they may seek medical attention, their main concern in doing so is the fear that the symptoms are indicative of having a serious, progressive or life-threatening illness. In contrast, individuals with Bodily Distress Disorder are typically preoccupied with the bodily

symptoms themselves and the impact they have on their lives, and while they may seek out health care providers who can determine the cause of their symptoms, they do so in order to get relief from the symptoms, not to disconfirm the belief that they have a serious medical illness.

6B24 Hoarding Disorder

Essential (Required) Features:

- Accumulation of possessions that results in living spaces becoming cluttered to the point that their use or safety is compromised. ***Note:*** If living areas are uncluttered this is only due to the intervention of third parties (e.g., family members, cleaners, authorities). Accumulation occurs due to both:
    - Repetitive urges or behaviours related to amassing items, which may be passive (e.g., accumulation of incoming flyers or mail) or active (e.g., excessive acquisition of free, purchased, or stolen items).
    - Difficulty discarding possessions due to a perceived need to save items and distress associated with discarding them.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Insight qualifiers:

Individuals with Hoarding Disorder vary in the degree to which they recognize that hoarding-related beliefs and behaviours (pertaining to excessive acquisition, difficulty discarding, or clutter) are problematic. For example, some can acknowledge that their living space presents a hazard, that many of the items they save are without value and unlikely to be of future use, or that their distress associated with discarding items is not rational, Others are convinced that their hoarding-related beliefs and behaviours are not problematic, despite evidence to the contrary, and the beliefs of some may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (e.g., an individual insists that items that objectively have little or no value are critically important to save or denies that there is any problem with their living space). Insight may vary substantially even over short periods of time, for example depending on the level of current anxiety or distress, such as when a family member or other person forces the individual to discard items. The degree of insight that an individual exhibits in the context of Hoarding Disorder can be specified as follows:

6B24.0 Hoarding Disorder with fair to good insight

- Much of the time, the individual recognizes that hoarding-related beliefs and behaviours (pertaining to excessive acquisition, difficulty discarding, or clutter) are problematic. This qualifier level may still be applied if, at circumscribed times (e.g., when being forced to discard items), the individual demonstrates no insight.

6B24.1 Hoarding Disorder with poor to absent insight

- Most or all of the time, the individual is convinced that hoarding-related beliefs and behaviours (pertaining to excessive acquisition, difficulty discarding, or clutter) are not problematic, despite evidence to the contrary. The lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.

Additional Clinical Features:

- Assessment for the diagnosis of Hoarding Disorder may require obtaining additional information beyond self-report such as reports from collateral informants or visual inspection of clutter in the home.
- Generally, items are hoarded because of their emotional significance (e.g., association with a significant event, person, place, or time), instrumental characteristics (e.g., perceived usefulness), or intrinsic value (e.g., perceived aesthetic qualities).
- Individuals with Hoarding Disorder may be unable to find important items (e.g., bills, tax forms), circulate easily inside their home, or even exit their home in the event of an emergency. Ability to prepare food, use sinks or home appliances (e.g., refrigerator, stove, or washing machine) or furniture (e.g., sofas, chairs, beds, tables) may also be compromised.
- Individuals with Hoarding Disorder may experience a range of chronic medical problems, such as obesity, and are exposed to various environmental risks often caused by their hoarding behaviour, including fire hazards, injuries from falling, contamination by rotting perishable foods, and allergies from contact with dust pollen and bacteria.

Boundary with Normality (Threshold):

- Collectors acquire many items that they report being attached to and reluctant to discard. However, they are also more targeted in their acquisitions (e.g., confining their acquisitions to a narrow range of items), more selective (e.g., planning and purchasing only predetermined items), more likely to organize their possessions, and less likely to accumulate items in an excessive manner.

Course Features:

- Hoarding behaviours often begin during childhood or adolescence and persist into later life. Onset after age 40 is rare.
- Hoarding Disorder is typically chronic and progressive.
- The consequences of hoarding become more severe and impairing with age due to accumulation of objects over time or secondary to an increased inability to discard or organize possessions because of the onset of comorbid physical and co-occurring mental disorders.
- Among the elderly, Hoarding Disorder is associated with impairment in a range of life-domains, including unsafe living conditions, social isolation, pathological self-neglect (i.e., poor hygiene), co-occurring mental disorders, and medical comorbidities.

Developmental Presentations

- Hoarding Disorder has its onset in childhood and adolescence (i.e., between the ages of 11 and 15) with prevalence rates reported as high as 2 to 3.7% by mid-adolescence. Later life onset may be a manifestation of the cognitive deficits and behavioural symptoms associated with Dementia (e.g., decreased inhibition or repetitive behaviour) rather than Hoarding Disorder.
- Excessive collecting and accumulation of clutter characteristic of Hoarding Disorder in adults may not be as evident among youth because caregivers may restrict excessive acquisition of objects. As such, hoarding is more likely to be restricted to particular areas (such as a child's bedroom) and types of materials (such as school-related objects, toys, and food) that the child can most easily access.
- Collecting and saving items is developmentally appropriate behaviour for young children up to the age of six making it more challenging for parents and clinicians to differentiate problematic hoarding from age-appropriate collecting and retaining objects.
- Individuals with Hoarding Disorder are more likely to experience co-occurring mental disorders or comorbid medical conditions, though this varies across developmental periods. Children and adolescents with hoarding symptoms are more likely to have co-occurring mental disorders, such as Obsessive-Compulsive Disorder or Attention Deficit Hyperactivity Disorder. Hoarding symptoms are also more common among youth with Autism Spectrum Disorder or Prader-Willi Syndrome. However, an additional diagnosis of Hoarding Disorder may be appropriate if the symptoms of each disorder require independent clinical attention. Among the elderly with Hoarding Disorder, Depressive Disorders, Anxiety or Fear-Related Disorders, and Post-Traumatic Stress Disorder are the most common co-occurring mental disorders.
- Hoarding occurring later in life has also been correlated with decreased memory, attention, and executive functioning, though the increased rates of co-occurring disorders such as Dementia and Depressive Disorders may also be involved.

Culture-Related Features:

- The nature of what is collected and the meaning, emotional valence, and value that people with Hoarding Disorder assign to their possessions may have cultural significance.
- Cultural values of thriftiness and accumulation should not be mistaken as evidence of disorder. In some cultural environments, saving items for later use is encouraged. This may be especially true in contexts of scarcity or within groups who experienced protracted periods of scarcity. Unless the symptoms are beyond what is expected of the cultural norms, these behaviours should not be assigned a diagnosis of Hoarding Disorder.

Gender-Related Features:

- Although prevalence rates for Hoarding Disorder are higher for women in clinical samples, some epidemiological studies have reported significantly higher prevalence rates among men.
- Men with Hoarding Disorder are more likely to have co-occurring Obsessive-Compulsive Disorder.

- Although the presenting features of Hoarding Disorder do not vary across gender, women tend to exhibit more excessive acquisition, particularly by means of compulsive buying.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Obsessive-Compulsive Disorder:*** Individuals affected by Obsessive-Compulsive Disorder may accumulate excessive amounts of objects (i.e., compulsive hoarding). However, unlike Hoarding Disorder, the behaviour is undertaken with the goal of neutralizing or reducing concomitant distress and anxiety arising from obsessional content such as aggressive (e.g., fear of harming others), sexual/religious (e.g., fear of committing blasphemous or disrespectful acts), contamination (e.g., fear of spreading infectious diseases), or symmetry/ordering (e.g., feeling of incompleteness) themes. Furthermore, even in individuals affected by Obsessive-Compulsive Disorder who have poor or absent insight, the behaviour is generally unwanted and distressing, whereas in Hoarding Disorder it may be associated with pleasure or enjoyment. However, if diagnostic requirements for both disorders are met, both diagnoses may be assigned.
- ***Boundary with Autism Spectrum Disorder:*** Autism Spectrum Disorder is characterized by restricted interests that may result in object accumulation and may also result in difficulty discarding objects due to distress associated with changes imposed on a familiar environment. However, individuals with Autism Spectrum Disorders display other symptoms that are typically lacking among individuals with Hoarding Disorder, including persistent deficits in social communication and reciprocal social interactions.
- ***Boundary with Delusional Disorder and other Primary Psychotic Disorders:*** In Schizophrenia or other Primary Psychotic Disorders, object accumulation may occur but is typically driven by delusions. Some individuals with Hoarding Disorder lack insight about the irrationality of their thoughts and behaviours to such an extent that convictions of the importance of acquiring and retaining items may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (see Insight qualifiers, page __). If these beliefs are restricted to the fear of discarding items or conviction that items have a special importance despite objective evidence to the contrary without a history of other delusions, that is, these beliefs occur entirely in the context of symptomatic episodes of Hoarding Disorder and are fully consistent with the other clinical features of the disorder, Hoarding Disorder should be diagnosed instead of Delusional Disorder. Individuals with Hoarding Disorder do not exhibit other features of psychosis (e.g., hallucinations or formal thought disorder).
- ***Boundary with Mood Disorders:*** Unlike individuals with Hoarding Disorder, those with Mood Disorders may exhibit hoarding secondary to depressive or manic symptomatology. In the case of Depressive Disorders, decreased energy, lack of initiative or apathy may lead to object accumulation, which unlike Hoarding Disorder, is done without any intention or purpose. Furthermore, individuals with Depressive Disorders may be indifferent to hoarding objects and display no distress associated with discarding them. In the case of Bipolar Disorders, object accumulation may be secondary to excessive buying that can occur during Manic Episodes. However, those with Bipolar Disorders do not have difficulty discarding or parting with possessions and only very rarely are Manic Episodes of sufficient duration to allow for a substantial amount of clutter to develop in the home.

- ***Boundary with Eating Disorders:*** Some individuals diagnosed with Feeding or Eating Disorders may accumulate large quantities of food to allow for binge eating in specific situations (e.g., while at home alone). However, in contrast to Hoarding Disorder, the purpose of accumulation is restricted to the consumption of food. Concerns about being or becoming overweight as well as body image distortions are not present in Hoarding Disorder.
- ***Boundary with Dementia:*** The symptoms are not a manifestation of Dementia, in which some individuals accumulate objects as a result of progressive neurocognitive deficit. Unlike Hoarding Disorder, individuals with Dementia display little interest in accumulating objects or distress associated with discarding items. Furthermore, collecting behaviour in Dementia may be accompanied by severe personality and behavioural changes, such as apathy, sexual indiscretions, and motor stereotypies.
- ***Boundary with Prader-Willi Syndrome:*** Prader-Willi Syndrome is associated with an increased drive to eat and a range of compulsive symptoms, including food storing. The presence of short stature, hypogonadism, failure to thrive, hypotonia, and a history of feeding difficulty in the neonatal period are helpful for the differential diagnosis with Hoarding Disorder.

6B25 Body-Focused Repetitive Behaviour Disorders

Body focused repetitive behaviour disorders are characterized by recurrent and habitual actions directed at the integument (e.g., hair pulling, skin picking, lip-biting), typically accompanied by unsuccessful attempts to decrease or stop the behaviour involved, and which lead to dermatological sequelae (e.g., hair loss, skin lesions, lip abrasions). The behaviour may occur in brief episodes scattered throughout the day or in less frequent but more sustained periods. The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

General Cultural Considerations:

- People who may inflict bodily harm to themselves (i.e., self-flagellation or self-cutting) as a part of religious ceremonies should not be assigned this diagnosis.

6B25.0 Trichotillomania (Hair Pulling Disorder)

Essential (Required) Features:

- Recurrent pulling of one's hair.
- Unsuccessful attempts to stop or decrease hair pulling.
- Significant hair loss results from pulling behaviour.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Additional Clinical Features:

- Hair pulling may occur from any region of the body where hair grows. However, the most common sites are the scalp, eyebrows, and eyelids. Less frequently reported sites are axillary, facial, pubic, and peri-rectal regions. Patterns of hair loss are variable with some areas of complete alopecia and others with thinning hair density.
- Individuals with Trichotillomania (Hair Pulling 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. Alternately, individuals may attempt to conceal or camouflage hair loss (e.g., by using makeup, scarves, or wigs).
- The diagnosis of Trichotillomania is typically made based on direct observation or physical examination of the hair loss. If this is not possible (e.g., because of religious proscriptions), then it may be difficult to make a judgment about the extent of hair loss. In such cases corroborative evidence may be required from a knowledgeable informant or physician who has conducted a physical examination of the individual.
- Hair pulling may occur in brief episodes scattered throughout the day or in less frequent but more sustained periods that can continue for hours. Hair pulling may endure for months or years before coming to clinical attention.
- Trichotillomania often presents with rituals surrounding hair such as visually or tactilely examining the hair or orally manipulating the hair after it has been pulled. Individuals who commonly swallow or eat the hair that has been pulled (trichophagia) can experience serious and even life-threatening gastrointestinal symptoms, depending on the volume of hair consumed.
- Focused hair pulling often increases during periods of increased psychological distress.
- Hair pulling behaviour is associated with a variety of reported effects including regulation of affect and arousal, tension-reduction, and promotion of pleasure, which presumably reinforce these behaviours. However, in the aftermath of hair pulling, many individuals report a variety of negative affective states, such as a sense of loss of control or shame. Individuals with Trichotillomania report varying degrees of awareness of their hair pulling behaviour.
- Excoriation Disorder is a common co-occurring condition in individuals with Trichotillomania. Trichotillomania also commonly co-occurs with depressive and anxiety symptoms, Obsessive-Compulsive Disorder, and other body-focused repetitive behaviours (e.g., nail biting).

Boundary with Normality (Threshold):

- Occasional pulling of a grey or out-of-place hair is normal and done by most people at some time in their lives. Many individuals also twist and play with their hair, whereas others may bite or tear rather than pull their hair; these behaviours do not qualify for a diagnosis of Trichotillomania (Hair Pulling Disorder). Trichotillomania involves recurrent hair pulling and is associated with significant distress or impairment, which are not present in occasional, normal pulling.

Course Features:

- Trichotillomania (Hair Pulling Disorder) is generally considered a chronic condition; however, for some individuals, symptoms may wax and wane for weeks, months, or

years at a time without intervention. Rates of remission decrease with increasing time since symptom onset.
- Patterns of hair pulling behaviour vary greatly and individual sites of hair pulling may change over time.

Developmental Presentations:

- Onset of Trichotillomania (Hair Pulling Disorder) is bimodal, with a peak during early childhood and one during early adolescence.
- Hair-pulling behaviour in infancy (i.e., before age of 2 years) is relatively common with most individuals ceasing to engage in the behaviour by early childhood. However, many adults reporting a chronic history of Trichotillomania describe early childhood onset. It is therefore unknown whether onset in early childhood (compared to adolescent-onset) presents as a distinct subtype of the disorder or what factors may contribute to persistence.
- Onset is most common in early adolescence, coinciding with puberty. Adolescent onset is associated with greater chronicity and impairment. Prevalence rates among adolescents are similar to adults (approximately 1 to 2% of the general population).
- Children and youth engage more frequently in automatic hair pulling, that is, they engage in the behaviour outside of awareness. Focused, intentional hair pulling is often preceded by intense urges and followed by relief is more common among adolescents and adults.
- The negative impact of hair pulling appears to become more severe across developmental periods. Children under age 10 appear to experience less academic impact than older children and adolescents, who tend to report more difficulties in school attendance and academic performance as a result of hair pulling.
- Similar to adults, children and adolescents with Trichotillomania appear to have high rates of co-occurring mental health disorders including Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Excoriation (skin-picking) Disorder, other Body-Focused Repetitive Behaviour Disorders, and Depressive Disorders. Children and adolescents may also be more likely to present with co-occurring Attention Deficit Hyperactivity Disorder.

Gender-Related Features:

- Prevalence rates appear to be equal among girls and boys in childhood, though female adolescents and adults are more commonly diagnosed.
- Although there is no evidence for gender differences in course and symptom presentation, men are more likely to experience a co-occurring Anxiety or Fear-Related Disorder or Obsessive-Compulsive Disorder.
- Focused hair pulling in women often increases during puberty as well as at other times of hormonal fluctuations during adulthood (i.e., menstruation, perimenopause).

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with other Obsessive-Compulsive or Related Disorders:*** Repetitive behaviours observed in Trichotillomania (Hair Pulling Disorder) occur in other Obsessive-Compulsive or Related Disorders but these are typically related to specific

foci of apprehension and are associated with distinct intent for each diagnostic entity. Individuals diagnosed with Obsessive-Compulsive Disorder may engage in hair pulling behaviour (e.g., as a symmetry ritual meant to 'balance' their hair). Furthermore, individuals with Obsessive-Compulsive Disorder, often exhibit other symmetry rituals alongside identifiable obsessions and compulsions unrelated to hair pulling. Nonetheless, co-occurrence with Obsessive-Compulsive Disorder is common and if both disorders are present both may be coded. Body Dysmorphic Disorder may be associated with removal of body hair that the individual perceives as ugly or as appearing abnormal.

- ***Boundary with Stereotyped Movement Disorder:*** A stereotyped movement is a repetitive, seemingly driven nonfunctional motor behaviour (e.g., head banging, body rocking, self-biting). These behaviours rarely include hair pulling behaviour but if they do, the behaviour tends to be composed of coordinated movements that are patterned and predictable. Furthermore, stereotyped movements are more likely to present very early in life (i.e., before 2 years of age), whereas Trichotillomania typically has an onset in early adolescence.
- ***Boundary with Schizophrenia and Other Primary Psychotic Disorders:*** Individuals with Schizophrenia or Other Primary Psychotic Disorder may remove hair in response to a delusion or hallucination. An additional diagnosis of Trichotillomania should not be assigned in such cases.
- ***Boundary with medical conditions classified elsewhere and Disorders Due to Substance Use:*** The symptoms are not a manifestation of another medical condition (e.g., inflammation of the hair follicles). Skin biopsy or dermoscopy are able to differentiate individuals with trichotillomania from those with dermatological disorders. Although hair pulling behaviour may be exacerbated by certain substances (e.g., amphetamine), there is no evidence that substances can be the primary cause of recurrent hair pulling.

6B25.1 Excoriation (Skin Picking) Disorder

Essential (Required) Features:

- Recurrent picking of one's skin.
- Unsuccessful attempts to stop or decrease skin picking.
- Significant skin lesions resulting from picking behaviour.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Additional Clinical Features:

- Trichotillomania is a common comorbid condition in individuals with Excoriation Disorder. Furthermore, Excoriation (Skin Picking) Disorder commonly co-occurs with depressive and anxiety symptoms, Obsessive-Compulsive Disorder, and other body-focused repetitive behaviours (e.g., nail biting).
- 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 a substantial minority use

tweezers, knives, or other objects. The Essential Features emphasize that skin picking must lead to skin lesions. However, individuals with this disorder often attempt to conceal or camouflage evidence of skin picking (e.g., using make-up or clothing). Therefore, careful assessment including information from collateral sources may be required to ascertain the presence of Excoriation Disorder symptomatology.

- Individuals with Excoriation Disorder often spend significant amounts of time on their behaviour, sometimes several hours each day. Skin picking may endure for months or years before coming to clinical attention.
- Excoriation Disorder often presents with rituals surrounding the skin such as visually or tactilely examining the skin, orally manipulating, or eating the skin or scab after it has been picked.
- Skin picking behaviour is associated with a variety of reported effects including regulation of affect and arousal, tension-reduction, and promotion of pleasure, which presumably reinforce these behaviours. However, in the aftermath of skin picking, many individuals report a variety of negative affective states, such as a sense of loss of control or shame. Individuals with Excoriation Disorder report varying degrees of awareness of their skin picking behaviour.

Boundary with Normality (Threshold):

- Occasional picking of one's skin (e.g., scabs, cuticles or acne) is normal and done by most people at some time in their lives. Some individuals bite their cuticles or surrounding skin; these behaviours do not qualify for a diagnosis of Excoriation (Skin Picking) Disorder. Excoriation Disorder involves recurrent picking and is associated with significant distress or impairment, which are not present in occasional, normal skin picking.

Course Features:

- Onset can occur at any age but most often coincides with onset or shortly after onset of puberty.
- The onset of Excoriation (Skin Picking) Disorder commonly occurs in association with dermatological condition, but the skin picking persists after the dermatological condition resolves.
- For some individuals an urge to pick at their skin may be preceded by emotional triggers such as increasing feelings of anxiety and tension or boredom. Others may pick at their skin in response to tactile sensitivity (i.e., skin irregularities) or bothersome skin sensations. In such cases, skin picking often results in an alleviation of tension, relief or a sense of gratification.
- Excoriation Disorder is generally considered a chronic condition. Some individuals may experience a waxing and waning of symptoms over weeks, months, or years at a time.

Developmental Presentations:

- Excoriation (Skin Picking) Disorder most often has its onset during adolescence typically corresponding to puberty. However, the emergence of symptoms can occur across the lifespan.
- Childhood-onset Excoriation Disorder is more prevalent among females.

- Automatic skin picking, which tends to occur unintentionally, outside of awareness, appears more frequently among individuals with childhood-onset Excoriation Disorder. Skin picking then appears to shift in adolescence and adulthood, as picking becomes focused. This picking appears to be generally intentional, connected to intense urges to pick, and often results in a sense of relief.

Gender-Related Features:

- Prevalence rates for Excoriation Disorder are significantly higher for women.
- Men have an earlier age of onset for the disorder.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with other Obsessive-Compulsive or Related Disorders:*** Repetitive behaviours observed in Excoriation Disorder occur in other Obsessive-Compulsive or Related Disorders but these are typically related to specific foci of apprehension and are associated with distinct intent for each diagnostic entity. Individuals diagnosed with Obsessive-Compulsive Disorder may engage in skin picking behaviour (e.g., when they experience contamination obsessions that are associated with behaviours intended to pick the skin to remove contamination). Obsessions do not precede skin picking in Excoriation Disorder, and individuals with Obsessive-Compulsive Disorder often exhibit other compulsions that are unrelated to skin picking. Nonetheless, co-occurrence with Obsessive-Compulsive Disorder is common and both disorders may be diagnosed if warranted. Body Dysmorphic Disorder may be associated with picking as a means of improving the individual's appearance by 'removing' acne or other perceived blemishes of the skin that the individual believes are ugly or that appear abnormal. Individuals with Excoriation Disorder do not pick skin with the sole purpose of correcting a perceived defect in appearance.
- ***Boundary with Stereotyped Movement Disorder:*** A stereotyped movement is a repetitive, seemingly driven nonfunctional motor behaviour (e.g., head banging, body rocking, self-biting). These behaviours rarely include skin picking behaviour but if they do, the behaviour tends to be composed of coordinated movements that are patterned and predictable. Furthermore, stereotyped movements are more likely to present very early in life (i.e., before 2 years of age), whereas Excoriation Disorder typically has a later onset.
- ***Boundary with Schizophrenia and Other Primary Psychotic Disorders:*** Individuals with Schizophrenia or other primary psychotic disorders may pick at their skin in response to a delusion or hallucination. Individuals with Excoriation Disorder do not report skin picking secondary to delusions or hallucinations.
- ***Boundary with Prader-Willi Syndrome:*** Individuals with Prader-Willi Syndrome may have early onset of skin picking more consistent with a Stereotyped Movement Disorder. Prader-Willi Syndrome is usually associated with a constellation of other symptoms such as Mild to Moderate Disorder of Intellectual Development, neonatal and infantile hypotonia, feeding problems and poor weight gain in infancy followed by hyperphagia and morbid obesity in childhood.
- ***Boundary with medical conditions classified elsewhere and Disorders Due to Substance Use:*** The symptoms are not a manifestation of another medical condition (e.g., scabies). However, skin picking may emerge following or be worsened by the presence of another condition (e.g., acne) and a diagnosis of Excoriation Disorder may

be applied in this circumstance if diagnostic requirements are met. Skin picking may also result from the use or misuse of stimulants (e.g., cocaine, methamphetamine, prescription stimulants), but Excoriation Disorder should not be diagnosed if the skin picking occurs exclusively in this context.

- ***Boundary with self-injurious and self-mutilating behaviours:*** Unlike self-injurious and self-mutilating behaviours, skin picking behaviours characteristic of Excoriation Disorder are not performed with the express purpose of self-injury though such injury may occur as a result.

6B2Y Other Specified Obsessive-Compulsive or Related Disorders

Essential (Required) Features:

- The presentation is characterized by symptoms that share primary clinical features with other Obsessive-Compulsive or Related Disorders (e.g., obsessions, intrusive thoughts and preoccupations; compulsions, recurrent and habitual actions directed at the integument).
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the Obsessive-Compulsive or Related Disorders grouping.
- The symptoms are not better accounted for by another Mental, Behavioural or Neurodevelopmental Disorder (e.g., a Primary Psychotic Disorder, an Impulse Control Disorder, an Anxiety or Fear-Related Disorder).
- The symptoms or behaviours are not developmentally appropriate or culturally sanctioned.
- The symptoms or behaviours are not a manifestation of another medical condition and are not due to the effect of a substance or medication on the central nervous system, including withdrawal effects.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.