



OBSESSIVE–COMPULSIVE AND RELATED DISORDERS

Obsessive-Compulsive Disorder • Body Dysmorphic Disorder
Hoarding Disorder • Trichotillomania • Excoriation Disorder

OVERVIEW

Obsessive-compulsive and related disorders (OCDs) is the umbrella term that describes disorders that have several features in common, including obsessions and compulsions.

Obsessions are persistent and intrusive thoughts, ideas, impulses, or images that result in anxiety. Often, the obsessive thoughts or worries are irrational and/or unrealistic. Compulsions are a temporary escape from the stress and anxiety associated with obsessions, and usually take the form of overt behavioral acts or rituals.

Figure 1 provides additional information about obsessions and compulsions.

Figure 1
Obsessions and Compulsions

Obsessions	<p>Recurrent and persistent thoughts, urges, or images the youth deems intrusive and unwanted at some point in the experience. Such thoughts, urges, or images are distressing and cause anxiety.</p> <p>The youth attempts to ignore or suppress the thoughts, urges, or images, or alternatively, neutralizes them with another thought or action (e.g., a compulsion).</p>
Compulsions	<p>Repetitive behaviors or mental acts the youth feels compelled to perform in response to an obsession.</p> <ul style="list-style-type: none">• Repetitive behaviors may include handwashing, ordering, checking, hoarding, hair pulling, skin picking, or other body-centric behaviors.• Mental acts may include such activities as counting or repeating words silently. <p>These behaviors/actions are performed in an attempt to prevent or reduce anxiety, distress, or a feared event. Actions are excessive and may not realistically be connected to that which they aim to prevent.</p>

Most youth experience the types of intrusive thoughts that cause distress in youth with OCDs. These thoughts may originate from a traumatic experience, illness, or information from others (e.g., family, friends, news reports). However, youth with OCDs may experience shame, guilt, or fear in response to these thoughts and have difficulty dismissing them. As a result of these unpleasant and/or fearful feelings, the youth attempts to escape or avoid the fear through various behaviors. If these behaviors become associated with the reduction in fear, they are reinforced—even if they do not directly cause fear to be reduced.

Younger children with OCRDs can present differently than adults. Adults with OCRDs often recognize that their behaviors are abnormal and problematic. However, due to undeveloped cognitive abilities, children with OCRDs may not understand that their behaviors are abnormal. In addition, they often cannot explain why it is important to complete a compulsion and may only report a vague sense that “something bad might happen.” Finally, their distress at not being able to complete a compulsion can manifest as tantrums or angry outbursts.

The impairment caused by OCRDs is significant. Because compulsions serve as the primary coping mechanism, youth with OCRDs who experience increased levels of distress will respond by increasing the intensity and/or magnitude of their compulsion. Thus, these youth may spend more and more time engaging in their rituals, which can interfere with school, work, and social functioning. Accordingly, youth with OCRDs may be reluctant to attend school for fear of embarrassment, and they often withdraw from social activities. Youth with OCRDs also possess a higher risk for comorbid anxiety disorders (e.g., social anxiety and panic disorder) and depression. While symptoms may fluctuate, the overall trend in symptom severity increases over the lifetime.

The main types of OCRDs are obsessive-compulsive disorder, body dysmorphic disorder, hoarding disorder, trichotillomania (hair-pulling disorder), and excoriation (skin-picking disorder). Because each category has different treatments, each will be discussed in its own section of this chapter. There are other uncommon OCRDs (Olfactory Reference Syndrome, Mysophobia, Emetophobia, and more), but they are not listed here.

Studies show that the suicide risk may be higher for youth who have OCRDs. While this risk does not solely affect children and adolescents, families should be aware of this risk and monitor their children for signs of suicidal ideation (thinking about suicide). For additional information on this topic, families should consult the “Youth Suicide” section of the *Collection*. If you are experiencing emotional distress or a suicidal crisis, dial “988” for the Suicide and Crisis Lifeline.

CAUSES AND RISK FACTORS

OCRDs tend to run in families, but they may develop even without any previous family history. The biological risk factors of OCRDs are genetic and have a neurological basis. OCRDs are not caused by parenting or other family issues. However, the way a family reacts to a youth with an OCRD can affect the disorder by either increasing or decreasing anxiety. For instance, one study found that parents of children with OCRDs (compared to parents of non-OCRD children) did not use problem-solving with their children as frequently, did not encourage their children’s independence, and did not have as much confidence in their children’s abilities.¹ In addition, physical and sexual abuse or severe trauma may contribute to the likelihood of developing the disorder.

PANDAS

There is evidence that a subset of children with obsessive-compulsive disorder developed symptoms after an infection of Group A beta hemolytic streptococcus (i.e., strep throat) or Sydenham’s chorea, a variant of

¹ Barrett, P., Shortt, A., & Healy, L. (2002). Do parent and child behaviours differentiate families whose children have obsessive-compulsive disorder from other clinic and non-clinic families? *Journal of Child Psychology and Psychiatry*, 43, 597-607.

rheumatic fever. This is called pediatric autoimmune neuropsychiatric disorder associated with strep (PANDAS). PANDAS is typically treated with antibiotics. While PANDAS is well accepted by some, there are still dissenters.

OBSESSIVE-COMPULSIVE DISORDER

Obsessive-compulsive disorder is characterized by elevated anxiety or distress caused by uncontrollable and intrusive thoughts (called obsessions) and repetitive, ritualistic behaviors (called compulsions). Obsessions and/or compulsions that take up a significant portion of the youth's day and that cannot be attributed to any other disorders are the hallmark of obsessive-compulsive disorder. Figure 1 in the Overview section details additional information about obsessions and compulsions.

The first challenge in diagnosing a child with obsessive-compulsive disorder is distinguishing developmentally appropriate beliefs and behaviors from those symptomatic of obsessive-compulsive disorder. For example, youth with obsessive-compulsive disorder may fear that, by merely thinking a thought (e.g., hurting a loved one), they will cause it to happen. In children, it is important to differentiate developmentally normal, magical thinking from pathological beliefs that drive compulsions and cause disproportionate distress. For instance, young children may insist on sameness and order or adhere to rigid routines, such as elaborate bedtime rituals, as part of normal development in early childhood, reflecting the need for mastery and control. Typical symptoms in youth also include eating rituals, unusual secretiveness, inability to make decisions, severe separation anxiety, and temper tantrums.

Assessment of obsessive-compulsive disorder should include obtaining complete developmental, medical, and family histories; evaluation of psychosocial functioning across multiple domains (e.g., family, friends, school, and home); and history of current and past symptoms. Both the parents and the child should complete diagnostic interviews to determine mental rituals and/or obsessions that the parent might not be aware of and behavior problems that the youth may be reluctant to report.

EVIDENCE-BASED TREATMENTS FOR OBSESSIVE-COMPULSIVE DISORDER

Effectively treating obsessive-compulsive disorder in youth is crucial to aiding in their lifelong functioning. Individual features of obsessive-compulsive disorder may have important implications for treatment. Mild obsessions or compulsions that are not the source of substantial distress or impairment may warrant monitoring over time. If such obsessions or compulsions are related to external or developmental stressors, psychotherapy or other psychosocial interventions targeted to these stressors may be useful. Treatments for obsessive-compulsive disorder are discussed in Table 1.

KEY POINTS

- **Characterized by:**
 - **Uncontrollable thoughts that cause distress (obsessions), and**
 - **Repetitive, ritualistic behavior meant to alleviate distress (compulsions).**
- **Evidence-based treatments include:**
 - **Cognitive behavioral therapy, which can involve the family and/or include exposure and response prevention therapy (ERP).**
 - **Medication therapy with approved SRIs or SSRIs.**

Table 1
Summary of Treatments for Obsessive-Compulsive Disorder

What Works	
Cognitive behavioral therapy (CBT) with exposure and response prevention (ERP)	Treatment path with a consistent and compelling relationship between the disorder, the treatment, and the specified outcome; combines training with exposure and preventing the accompanying response.
Family-focused individual CBT	Individual CBT that includes a focus on family involvement. It should be noted that the distinction of family focused here is meant to imply a format for treatment delivery.
Serotonin reuptake inhibitors (SRIs)	Clomipramine: Approved for children aged ten and older; recommend periodic electrocardiographic (ECG) monitoring.
Selective serotonin reuptake inhibitors (SSRIs)	Fluoxetine (Prozac): Approved for children aged eight and older. Sertraline (Zoloft): Approved for children aged six and older. Fluvoxamine (Luvox): Approved for children aged eight and older.
What Seems to Work	
Family-focused group CBT	Studies show promising results, but there have only been a small number of studies. However, each study addresses complex comorbidity and issues impacting community-based treatment.
Not Adequately Tested	
CBT without ERP Psychodynamic therapy Client-centered therapy	Systematic controlled studies have not been conducted using these approaches.
Technology-based CBT	Results show preliminary support for telephone CBT and web-camera CBT. Although these results are encouraging, caution must be taken due to the small sample sizes and lack of active control groups.
Deep Brain Stimulation (DBS)	Involves implanting electrodes in the brain to monitor abnormal impulses. There is strong evidence for success in young adults, but not enough adolescent studies.
What Does Not Work	
Antibiotic treatments	Antibiotic treatments are only indicated when the presence of an autoimmune or strep-infection has been confirmed and coincided with onset or increased severity of obsessive-compulsive disorder symptoms (PANDAS).
Herbal therapies	Herbs, such as St. John’s Wort, have not been rigorously tested and are not FDA approved. In some instances, herbal remedies may make symptoms worse or interfere with medications.

Psychosocial Treatments

Cognitive behavioral therapy (CBT) that includes exposure and response prevention (ERP) therapy is the clinically standard first treatment path for obsessive-compulsive disorder in youth. Research suggests that ERP-based CBT may be more effective than pharmacological treatments. Both individual and individual family-based CBT treatments have been shown to be effective.

Clinicians should treat mild to moderate cases of obsessive-compulsive disorder youth with CBT, and for moderate to severe cases, CBT should accompany pharmacotherapy. For caregivers wondering what questions to ask a therapist during diagnosis, the Anxiety and Depression Association of America has an extensive list.

Pharmacological Treatment

Although traditionally used to treat depression, three selective serotonin reuptake inhibitors (the SSRIs fluoxetine (Prozac), sertraline (Zoloft), and fluvoxamine (Luvox)) and one serotonin reuptake inhibitor (the SRI clomipramine) are approved by the FDA for treatment of obsessive-compulsive disorder in youth.

While these medications may be helpful in conjunction with CBT treatments, they are not without risks and side-effects. For instance, in high doses, clomipramine has been associated with seizures and electrocardiographic (ECG) changes. Youth taking clomipramine should receive periodic ECG monitoring. Other side effects of clomipramine include dry mouth, constipation, dizziness, postural hypotension, sweating, and sedation.

There has also been greater awareness of an increased risk of suicidal ideation in youth taking antidepressants, including SSRIs. These risks must be weighed against the potential benefit from the medication when making treatment decisions. Youth taking these medications should be monitored for potential medical or psychological side-effects throughout treatment, particularly if other medications are also prescribed. The interaction of medications is poorly researched, particularly in children and adolescents; therefore, combinations of medications should be carefully considered. For additional information on this topic, please refer to the *Collection's* section "Antidepressants and the Risk of Suicidal Behavior."

BODY DYSMORPHIC DISORDER

Body dysmorphic disorder causes affected youth to perceive deficits in their physical appearance. Concerns about weight or body fat are related to eating disorders, not body dysmorphic disorder. However, the body imperfections characterizing body dysmorphic disorder are either not observable or only slightly observable to others. A child or adolescent with body dysmorphic disorder may seek out (possibly repetitive or compulsive) ways to fix these perceived flaws by: checking the mirror, seeking surgery or cosmetic

KEY POINTS

- **Characterized by obsessions and compulsions related to perceived physical deficits (not including body weight).**
- **Physical deficits are not readily perceivable to others.**
- **Occurs when no other mental disorder, for example, an eating disorder, is causing these consuming feelings.**
- **No evidence-based treatments at this time, but cognitive behavioral therapy and medication therapy (SSRIs) show promise.**

procedures, exercise or groom excessively, skin picking, changing clothes frequently, and/or seeking reassurance repetitively. Moreover, the child may compare his or her appearance to others. Muscle dysmorphia is a form of body dysmorphic disorder evidenced by a concern that one is too small or not muscular enough.

Males and females are equally likely to present with body dysmorphic disorder symptoms. The median onset age is 15 years; however, the most common onset age is 12 to 13 years. Almost two thirds of those with body dysmorphic disorder experience onset prior to age 18. These individuals are more likely to have a gradual onset and are more likely to attempt suicide. As compared to youth without BDD, youth who have BDD are four times more likely to have suicidal thoughts and 2.6 times more likely to attempt suicide.² Clinicians should be aware of the potential for slow onset suicide ideation.

It is important that the clinician distinguishes normal adolescent concerns from body dysmorphic disorder concerns. In addition, developmental changes in the adolescent brain may contribute to the onset of body dysmorphic disorder.³ These changes increase adolescents' self-consciousness and awareness of social status. Therefore, body dysmorphic disorder may be a disordered response to the psychological, social, and physical changes of adolescence itself.

TREATMENT FOR BODY DYSMORPHIC DISORDER

Unfortunately, there are no evidence-based treatments yet available for youth with body dysmorphic disorder. CBT shows promise because of its effectiveness with similar disorders, as does pharmacotherapy. Treatments are presented in Table 2.

Table 2
Summary of Treatments for Body Dysmorphic Disorder

What Works	
There are no evidence-based practices at this time.	
Not Adequately Tested	
Selective serotonin reuptake inhibitors (SSRIs)	Possibly effective because of effectiveness with similar disorders.
Cognitive behavioral therapy (CBT)	Shows promise because of effectiveness with similar disorders.

² Angelakis I, Gooding PA, Panagioti, M. (2019). Suicidality in body dysmorphic disorder (BDD): a systematic review with meta-analysis. Retrieved from <https://pmc.ncbi.nlm.nih.gov/articles/PMC6343413/#ref19>.

³ Smith, A. R. (2011). When body image becomes a disorder. Retrieved from https://www.counseling.org/docs/default-source/vistas/vistas_2011_article_09.pdf?sfvrsn=11http://counselingoutfitters.com/vistas/vistas11/Article_09.pdf.

HOARDING DISORDER

Hoarding disorder is characterized by ongoing difficulty discarding or parting with possessions (regardless of value), perceived need to save the items, and distress associated with discarding them. Individuals with hoarding disorder accumulate and retain so many items that they congest their living area and substantially compromise the use of the retained items.

Hoarding disorder begins to present symptoms around 11 to 15 years of age, begins to interfere with life around the mid-20s, and causes clinically significant impairment by the mid-30s.

Hoarding can be distinguished from collecting by analyzing how the youth views his or her possessions. Generally, collectors are proud of their possessions and experience joy in displaying and discussing them. Alternatively, those who hoard are embarrassed about their possessions and feel uncomfortable when others see them. Clutter often replaces livable space, and the owner is sad or ashamed after acquiring additional items. Debt frequently accompanies hoarding disorder.

KEY POINTS

- **Characterized by overaccumulation of items and difficulty parting with items, which often causes embarrassment and distress.**
- **No evidence-based treatments at this time, but cognitive behavioral therapy tailored to hoarding seems to work.**

TREATMENTS FOR HOARDING DISORDER

Unfortunately, no treatments that meet the level of evidence-based standards are available for youth with hoarding disorder. Historically, hoarding as a symptom of an OCD did not react well to medication or standard CBT, although CBT treatment designed specifically for hoarding has shown success in limited trials. Treatments are presented in Table 3.

Table 3
Summary of Treatments for Hoarding Disorder

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Cognitive behavioral therapy (CBT) for hoarding	A multi-component, cognitive behavioral treatment designed specifically for hoarding has shown promising results in adults.
Not Adequately Tested	
Selective serotonin reuptake inhibitors (SSRIs)	Possibly effective because of their effectiveness with similar disorders.

TRICHOTILLOMANIA AND EXCORIATION DISORDER

TRICHOTILLOMANIA (HAIR-PULLING DISORDER)

Trichotillomania involves hair pulling from some or many body parts, including the scalp. Some studies suggest that there are two subtypes of pulling: automatic pulling, which occurs largely outside of the individual's awareness, and focused pulling, which is a deliberate response to an urge, unpleasant emotion, or sensation. In addition to subtypes, hair pulling is often accompanied by ritual, such as choosing the right type of hair, pulling it with the root intact, or examining or manipulating the hair after pulling, including rolling it between fingers, biting, or swallowing it. Usually hair pulling only occurs when the individual is alone or around immediate family. Some individuals will pull hair from others in secret, or from rugs or dolls to satisfy their urges. Youth may report triggers such as tension, anxiety, or specific cognitions like the appearance of the hair, an itch, boredom, or specific settings. Trichotillomania onset typically begins during childhood or early adolescence.

Hair loss must occur to diagnose trichotillomania, but some youth will pull individual hairs throughout an area such that hair loss is less obvious. Additionally, individuals may wear hats or wigs to camouflage hair loss.

EXCORIATION DISORDER (SKIN PICKING DISORDER)

Excoriation (skin-picking) disorder is characterized by picking at one's own skin, including healthy skin, calluses, and pimples. Individuals with excoriation disorder pick at actual and perceived skin defects, leading to physical damage. Most individuals use fingernails, but they may also use tweezers or pins, and they may also rub or squeeze the skin. The individual will frequently seek out a scab or other area to pick, and then examine, play with, or mouth the removed piece of skin or scab. Some picking is focused, with preceding anxiety or tension and subsequent relief, while in others picking is automatic without full awareness. Most individuals engage in both focused and automatic picking. For a diagnosis of excoriation, skin picking must lead to physical damage.

Skin picking may occur as a result of boredom or anxiety, and it may lead to a sense of gratification when successfully completed. At least some symptoms of skin picking can be common. Only when the symptoms reach the criteria for skin picking disorder (lesions, an attempt to stop, and accompanying distress) should the symptoms require intervention. Some research suggests that excoriation most frequently occurs in females from teens to late 30s.

KEY POINTS

- Trichotillomania is characterized by compulsive pulling and removing body hairs, which results in significant hair loss.
- Excoriation disorder is characterized by compulsive picking of one's skin, leading to physical damage.
- No evidence-based treatments at this time, but habit reversal therapy and cognitive behavioral therapy seem to work.

TREATMENTS FOR TRICHOTILLOMANIA AND EXCORIATION DISORDER

Research exploring treatments for childhood trichotillomania and excoriation is promising, but the treatments have not been researched sufficiently enough to warrant the designation of evidence-based treatment. These and other treatments are summarized in Table 4.

CBT is emerging as a promising treatment for trichotillomania and excoriation disorder. CBT for these disorders involves many components common to habit reversal therapy (HRT), such as awareness training and developing a competing response. However, CBT treatments also incorporate several additional elements like psychoeducation and cognitive skills that are thought to provide additional benefits. Psychoeducation entails teaching youth and parents about the disorder and how to monitor behavior. Cognitive restructuring helps youth identify and change maladaptive beliefs associated with stressful situations and to distinguish between minor setbacks and full-blown relapses.

Components have also been added to HRT to target additional problems. In the treatment of trichotillomania or excoriation disorder, therapists may employ either emotion-regulation techniques (which help youth learn more adaptive ways of coping with emotion) or cognitive restructuring (which helps youth recognize and change the thoughts or emotions that occur before or after pulling or picking).

Table 4
Summary of Treatments for Trichotillomania and Excoriation

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Habit reversal therapy (HRT)	Treatment increases awareness to the feelings and context associated with the urges and implements a competing and inconspicuous habit in place of the hair pulling and skin picking.
Cognitive behavioral therapy (CBT)	Treatment involves exposing children to the stimuli associated with the urge, while challenging thoughts associated with high-risk situations.
Not Adequately Tested	
Selective serotonin reuptake inhibitors (SSRIs) N-acetylcysteine Naltrexone	Some demonstrated improvement on certain measures of picking behavior has been shown in some pharmacological studies of adults.

RESOURCES AND ORGANIZATIONS

Anxiety and Depression Association of America (ADAA)

<https://adaa.org>

Association for Behavioral and Cognitive Therapies (ABCT)

<https://www.abct.org/>

International OCD Foundation

<https://iocdf.org>

Mayo Clinic

Obsessive-Compulsive Disorder

<https://www.mayoclinic.org/diseases-conditions/obsessive-compulsive-disorder/symptoms-causes/syc-20354432>

Mental Health America (MHA)

Obsessive-Compulsive Disorder

<https://mhanational.org/conditions/obsessive-compulsive-disorder-ocd/>

Trichotillomania

<https://mhanational.org/conditions/trichotillomania-hair-pulling/>

National Alliance on Mental Illness (NAMI)

<https://www.nami.org/>

National Institute of Mental Health (NIMH)

Obsessive-Compulsive Disorder

<https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd/index.shtml>

TLC Foundation for Body-Focused Repetitive Behaviors

<http://www.bfrb.org/>

Society of Clinical Child and Adolescent Psychology

<https://sccap53.org/>

Substance Abuse and Mental Health Services Administration (SAMHSA)

<http://www.samhsa.gov/>

VIRGINIA RESOURCES AND ORGANIZATIONS

National Alliance on Mental Health (NAMI) Virginia

<https://namivirginia.org/>

VCU Health - Children's Hospital of Richmond

Cameron K. Gallagher Mental Health Resource Center

<https://www.chrichmond.org/services/mental-health/cameron-k-gallagher-mental-health-resource-center>

Virginia Treatment Center for Children (VTCC)

<https://www.chrichmond.org/services/mental-health/>

Virginia Department of Behavioral Health and Developmental Services (DBHDS)

<http://www.dbhds.virginia.gov/>

Virginia Tech

Child Study Center

<http://childstudycenter.wixsite.com/childstudycenter>

Psychological Services Center

<https://support.psyc.vt.edu/centers/psc>

University of Virginia Children's Hospital

Obsessive-Compulsive Disorder

<https://childrens.uvahealth.com/services/pediatric-psychiatry/obsessive-compulsive-disorder-ocd>

The Collection of Evidenced-Based Practices for Children and Adolescents with Mental Health Treatment Needs, 10th Collection
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