BFRB

Body Focused Repetitive Behaviours

Body-Focused Repetitive Behaviours, or BFRBs, are a cluster of habitual behaviours that include hair pulling, skin picking, nail biting, nose picking, and lip or cheek biting. Currently, the most recent edition of the clinician's diagnostic manual (DSM-5), has listed both hair pulling, called Trichotillomania, and skin picking, called Skin Excoriation, as BFRBs that are of clinical concern. These are listed under the section, Obsessive Compulsive and Related Disorders, and are described in detail here.

Trichotillomania (TTM)

Three primary features define TTM:

- Ongoing and repetitive pulling out of one's hair resulting in noticeable hair loss.
- The most common sites are the head and face (i.e., eyebrows and lashes), although youth also pull from other areas such as the arms and legs, the pubic region, under the arm, as well as on other individuals and even from pets, such as cats and dogs. Children are less likely than adults to pull from multiple sites, often favoring a single location.
- Repeated but unsuccessful attempts to reduce or stop the pulling.
- Significant impairment or disruption in routine life functioning.

Additional features of TTM:

- Youth with TTM engage in two types of pulling behaviour: focused and/or unfocused/automatic pulling, with many individuals experiencing both types. Focused pulling typically occurs in response to an internal state (e.g., anxiety, boredom, sadness, shame, etc.), often triggered by an external event (e.g., a fight with a friend, or the memory of that fight), and is more common in older adolescents and adults. In contrast, automatic pulling usually occurs out of the individual's awareness, often during sedentary activities such as watching television, reading, or playing. It is this type of pulling that predominates in children.
- Pulling episodes can last several minutes to over an hour or more in duration.
- In order to successfully extract the hair, the youth may use their thumb and index finger, other finger combinations, or tweezers to pull one hair at a time. Pulling clumps of hair is unusual.
- Pulling episodes often include a variety of component parts as follows:
- Fingers being close to the area (e.g., elbow resting on arm of chair, and head resting on hand).
- Fingers touching the area (e.g., smoothing down eyebrows or hair twirling).
- Fingers seeking out the "optimal" hair. For some children this will be a thicker hair, or a hair with a bulbous follicle.
- Internal arousal or mounting tension (not typical in younger children).
- Manipulating and then pulling the hair.
- Playing with the hair. This may be with fingers alone, or rolled on the face and lips, and in some youth, chewed on and even swallowed.

- As it is rare for an individual to pull only a single hair, throughout the entire pulling episode, the individual typically experiences a flood of pleasurable sensations such as relaxation, as well as relief from negative feelings such as boredom, frustration, or loneliness. Pain often occurs in equal measure with pleasure in children.
- A critical piece that contributes to youth continuing to pull despite the often-obvious signs of damage (e.g., bald spots), as well as a strong desire to stop the behaviour often due to shame and embarrassment, are the pleasant feelings that result from pulling, as well as the relief from negative emotional states, during an episode. These aspects are a powerful form of self-soothing that is highly rewarding and thus difficult to resist, when urges to pull arise.

Facts:

TTM occurs in 1-3% of children and adults during their lifetime, with the average age of onset in early adolescence although it can start as early as age one.

There is no known cause, although research suggests TTM is a neurobehavioral disorder with genetics contributing to the onset.

Younger children are more likely to engage in automatic pulling, with no reported awareness of tension before, and pleasure after, each pull.

A range of physical effects can occur in individuals with TTM including formation of Trichobezoars, hairballs, in the gastrointestinal tract that sometimes will require surgery, atypical regrowth of hair, dental damage, carpal tunnel syndrome, among other conditions.

SIGNS & SYMPTOMS:

Thoughts & Beliefs (Note: very young children may be unable to identify specific thoughts):

- I must make them symmetrical (eyebrows)
- It’s the only thing that makes me feel calm and relaxed
- I can’t stand to have thick hairs growing in
- I’m helpless to control it
- I’m a perfectionist

Physical feelings:

- Derealization (out of body experience)
- Exhaustion and fatigue
- Internal arousal or mounting tension
- Muscle tension
- Pleasure, relief, or gratification
- Urges to pull, or even things out

Emotions:

- Anxiety/worry/stress
- Boredom
- Frustration and anger
- Guilt
- Loneliness
- Pleasure and happiness
- Sadness

- Shame and embarrassment

Behaviours and external signs:

- Avoidance of others and social isolation
- Hair loss
- Missed work or school
- Pulling the hair
- Playing with the hair including eating it
- Reduced academic or job opportunities
- Touching, smoothing, and manipulating the area

COMMON SITUATIONS OR AFFECTED AREAS

- Avoiding routine activities such as swimming, getting hair cut/colored, medical visits, and more
- Financial strain upon the family due to cosmetic costs to cover or correct hair loss
- Impaired relationships including reduced romantic intimacy and social isolation
- Missed school or related activities
- Trouble concentrating or sustaining attention in school
- Excoriation Disorder

Another BFRB of clinical relevance is **Excoriation Disorder**, which shares many of the same features as TTM. The three primary features of SE are:

- Ongoing and repetitive picking of one's skin that may or may not be triggered by a visible scab or other mark (e.g., bug bite or pimple), which due to the force of picking, creates or worsens a skin lesion. The most common sites are the face, arms, and hands, although other body parts can also be a target, such as the legs and pubic areas where ingrown hairs may be more frequent.
- Repeated but unsuccessful attempts to reduce or stop picking.
- Significant impairment or disruption in routine life functioning, such as social isolation and/or problems with academic or job success, permanent scarring, low self-esteem, financial strain upon the family, and more.

Additional features of SE:

- As in youth with TTM, youth with SE also report that the picking behaviour exists as either a focused or unfocused/automatic activity. Focused picking typically occurs in response to an internal state (e.g., anxiety, sadness, shame, etc.), often triggered by an external event (e.g., seeing themselves in the mirror or feeling a pimple), whereas automatic picking usually occurs out of the individual's awareness often during more sedentary activities such as watching television, reading, or typing. This latter type of picking often also involves touching, rubbing, squeezing, biting, and other forms of manipulation of the area.
- Prior to picking, some children report internal arousal or mounting tension that will increase in intensity if the urge is not met, followed by pleasure or relief after picking.
- Picking episodes can last several minutes to over an hour or more in duration. If one also includes time spent anticipating a picking episode and thus being distracted from the task at hand (e.g., schoolwork), episodes can consume hours each day.

- The child or adolescent typically will use the fingernails to pick, but other methods can include tweezers, pins and other related objects. The youth may then play with, or even eat, the resulting scab or skin.
- Once more, like youth with TTM, a critical piece that contributes to ongoing picking despite the often obvious signs of damage (e.g., open sores and scarring), as well as a strong desire to stop the behaviour often due to shame and embarrassment, are the pleasant feelings that result from picking, as well as the relief from negative emotional states, during an episode. These aspects are a powerful form of self-soothing that is highly rewarding and thus difficult to resist, when urges to pull arise.

Facts:

- SE occurs in approximately 1.5% of individuals during their lifespan.
- SE is a secretive behaviour, and thus except for close family members, most children will only pick in private.
- A range of physical effects can occur in youth with SE including tissue damage, scarring and infection, with surgery required in extreme cases.

SIGNS & SYMPTOMS:

Thoughts & Beliefs (Note: very young children may be unable to identify specific thoughts):

- I must make do something to make this look better
- It's the only thing that makes me feel calm and relaxed
- I can't stand to have imperfections in my skin
- I look ugly
- I'm helpless to control it

Physical feelings:

- Exhaustion and fatigue
- Internal arousal or mounting tension
- Loss of control
- Muscle tension
- Pleasure
- Relief
- Urges to pick or clean things out

Emotions:

- Anxiety/worry/stress
- Boredom
- Frustration and anger
- Guilt
- Loneliness
- Pleasure and happiness
- Sadness
- Shame and embarrassment
- Behaviours and external signs:
- Avoidance of others and social isolation
- Missed work or school

- Picking at skin
- Playing with the skin including eating it
- Reduced academic or job opportunities
- Scars and skin lesions
- Touching, smoothing, and manipulating the area

COMMON SITUATIONS OR AFFECTED AREAS

- Family financial strain due to cosmetic costs to cover or correct skin damage
- Impaired relationships including reduced romantic intimacy and social isolation
- Missed school or related activities
- Modifying hair, and using hats, long shirts, and other clothing to hide lesions, scabs, etc.
- Trouble concentrating or sustaining attention in school

Health Anxiety

Health Anxiety in Children

Health anxiety is a disorder. There are several disorders that are defined by excessive anxiety related to somatic symptoms or an illness or condition. For youth with these disorders there is a preoccupation with one or more somatic symptoms or having or getting a serious illness.

Naturally occurring sensations are often misinterpreted as evidence for illness, and consequently the children with health anxiety are easily alarmed about his or her health. The worry typically leads to excessive checking behaviours to ensure they aren't sick, such as frequent visits to medical professionals and use of home devices (e.g. a thermometer, looking up illnesses on the internet), as well as persistent questioning of others to determine whether they are ill, and other reassurance seeking. Alternatively, the youth may refuse medical attention completely due to fear of what may be discovered. Even when a child does have an illness or condition, the degree of worry and related checking behaviours are far more extreme and time consuming than would be expected given the situation. Although many youth may worry about health and general wellness on occasion, for youth with health-related anxiety this worry is excessive, ongoing, uncontrollable, physically draining, and significantly negatively impacts the quality of life of the child and their family.

Fear or Fact Seeking: Chronic Medical Conditions and Worry

While children with health anxiety do not always have a medical condition, some do. If your child has a chronic medical condition such as asthma, food allergies, diabetes, and others, s/he can also have a health anxiety disorder. But how do you tell what is reasonable worry that can understandably occur with a life-threatening allergy to peanuts, versus whether your child might have a health anxiety disorder? In order to make this determination it is recommended you seek an assessment by a medical or mental health professional. However, as a parent you can contribute to that assessment by starting to observe whether your child's behaviours are a result of fear or fact seeking. Children with excessive anxiety about their medical condition are ruled by fear. Fear tells them not to go to a friend's home because their medical condition might flare up or convinces them to stay home sick from school because the teacher might not be able to help. Fear bosses them about daily even when you have provided information to calm

their worries, many, many times, or have explained why their behaviours are unnecessary. In fact, you know fear is in charge when you seem to be providing the same information repeatedly, but your child never feels better. Fact seeking on the other hand allows a child with a chronic condition to understand the dos and don'ts to managing and living with his/her condition. Although s/he may have some worry about how to cope, s/he seeks out relevant facts that make him/her feel confident to cope and thrive. This can include identifying community members who will help when you, the parent, are not available, and taking reasonable precautions outlined by your child's doctor to ensure his/her condition remains stable. As a result, your child can engage in his/her daily life with minimal disruption and if they experience small doses of worry, this creates little interference.

SIGNS & SYMPTOMS

Thoughts (very young children may be unable to identify fears):

- What if my cold turns into pneumonia and I die?
- I've had three headaches this year. I'm sure I have a brain tumor!
- What if that pain means I have cancer?
- I don't think my doctor is qualified enough.
- No one understands me.

Physical feelings:

- Irritability
- Tiredness or fatigue
- Muscle pains
- Headaches
- stomach-aches

Emotions:

- Anxiety or worry
- Sadness
- Anger
- Frustration
- Guilt

Behaviours:

- Tantrums
- Difficulty falling or staying asleep, or disturbed/interrupted sleep
- Excessive body checking
- Reassurance seeking
- Researching illness and treatments
- School refusal

COMMON SITUATIONS OR AFFECTED AREAS

- School absenteeism
- Frequent trips to medical professionals
- Inability to participate and enjoy recreational activities and clubs due to trying to

prevent exposure to perceived germs or illnesses

- General decline in quality of life – less involved in activities, limited interests, increased time spent worrying
- Unusual or overly focused interests- frequent research of medical illnesses and treatments, becoming an expert on identifying diseases, etc.

How health related anxiety impacts the child at different ages

Young children typically worry about a single symptom like a headache or stomach pain, or a condition they have, rather than a specific illness. For some this worry stems from a lack of understanding, and can be managed through basic education, but for others the worry persists. As children mature, but while their capacity for abstract reasoning remains undeveloped, some children may engage in extreme leaps of logic such as worrying about dying from a cold or catching cancer. As children get older, however, their thinking evolves, and specific worries may become more complex or future oriented. For example, "What if that pain means I have Leukemia?" or "What if the effects of MSG and GMO foods build up in my blood stream and I get cancer in my thirties?" Despite the variety of what worries youth, most youth with health-related anxiety are unable to recognize that their chronic focus on symptoms or illness, and related behaviours, is unreasonable because they are so anxious. The anxiety trumps logic. In addition, the negative impact of the ongoing, constant worry becomes more disruptive and pervasive over time. It may take less energy to reassure your seven year old that leg pain is probably bone growth and not cancer when the worry has existed for a week; whereas when it has persisted for months or even years, your child may become increasingly demonstrative and aggressive in his demands to have a second or even third opinion from a "more qualified" professional. The bottom line is that excessive and uncontrollable worry about health is not a typical characteristic for youth, and left unaddressed can significantly negatively impact his/her quality of life.

OCD

Obsessive Compulsive Disorder (OCD) involves unwanted and disturbing thoughts, images, or urges (obsessions) that intrude into a child/teen's mind and cause a great deal of anxiety or discomfort, which the child/teen then tries to reduce by engaging in repetitive behaviours or mental acts (compulsions).

Often, compulsions are performed in a ritualistic, or very specific way, for example, counting to six each time an article of clothing is removed.

The following lists common obsessive themes and compulsive rituals:

Obsessions

Contamination Fear or distress about encountering dirt, germs, sticky substances, or chemicals (e.g., household cleansers), or getting sick, or getting others sick after touching "dirty" or "contaminated" items

Accidental harm to self or others Fear of harming yourself or others through carelessness. For example, "what if I didn't clean off the counter properly and there are still germs on it, and my mom gets sick because of me!"

Symmetry and exactness A need to have items ordered in a certain way (for example, according to color, size, or facing a certain direction). Children and teens with this type of obsession are either anxious because "it just doesn't feel right" or because of a superstitious belief that something bad will happen (e.g., "if my shoes are not arranged properly, my mom will die!"). Often, the content of obsessions sounds very odd or makes no sense. For example, a child with OCD might say that he or she needs to arrange all the teddy bears from smallest to biggest or else something bad will happen to mom. Most children and teens are aware that these thoughts are strange; however, do not be surprised if your child doesn't think his or her thoughts are odd. Most younger children have no idea that their obsessions sound peculiar to others.

A need for perfection Some kids and teens feel a strong need for things to be perfect or right. For example, your child might not be able to start her homework until her books are all ordered and perfectly arranged or cannot turn in an assignment until she is certain its perfect. Other kids struggle to tolerate if something isn't 100% right, focusing on doing the right thing all the time or thinking about every tiny mistake.

Forbidden thoughts Entering into adolescence is a time of sexual maturity and most teens think about sex and sexual identity during this time. However, for some teens they are plagued with unwanted thoughts and images about being gay when they know they are not or thinking about engaging in sexual behaviour that feels upsetting and even repulsive to them.

Compulsions

- Washing or cleaning Washing hands excessively, sometimes until they are raw and bleeding. There are many other types of washing behaviours, including:
- Toilet rituals (e.g., excessive wiping)
- Grooming/tooth brushing rituals (e.g., brushing each tooth in a particular order)
- Showering rituals (e.g., washing each body part a certain number of times or in a particular order)
- Cleaning compulsions (e.g., rituals and rules for how to wash laundry, clean the bathroom, kitchen, etc.)

Checking These types of compulsions can involve checking doors, locks, or backpacks, to make sure everything is safe. Some children and teens check to make sure that everyone is okay. For example, calling family members to "check" that they are safe.

Counting, tapping, touching, or rubbing Compulsions can involve counting, touching, or tapping objects in a particular way. Some children and teens have lucky and unlucky numbers involved in their rituals (e.g., needing to touch a door four times before leaving a room).

Ordering/arranging This compulsion involves arranging items in specific ways, such as bed sheets, stuffed animals, or books in the school locker or book bag. For example, a child might need to line up all the shoes in the closet so that they all face forward and are matched by color.

Mental rituals Not all children and teens with OCD will have compulsions that can be seen. Some perform rituals in their head, such as saying prayers or trying to replace a "bad" image or thought with a "good" image or thought. For example, a teen might have a bedtime prayer that

he or she mentally repeats over and over again until it “feels right”.

Facts:

- OCD can begin early, starting between ages seven and 12. In fact, up to half of all adults with OCD say their symptoms started when they were children
- OCD is more common in boys than girls in childhood, but into adulthood, women are affected at a slightly higher rate than men
- OCD symptoms can change over time. For example, when OCD first appears your child might begin with excessive washing compulsions, but over time this can shift to excessive checking compulsions while compulsive washing disappears
- OCD occurs in 2-3% of children and adults during their lifetime
- Seeking reassurance from others that things will be okay or a ritual was completed “correctly” is common in children and teens with OCD. This can include asking parents and siblings to do rituals as well

Signs & Symptoms:

Thoughts (Note: very young children may be unable to identify specific fear thoughts):

- I’m responsible for that accident
- What if I get sick?
- If I don’t get an A on this paper my future is ruined
- Am I attracted to that guy? Do I find him good looking? This must mean i’m gay
- What if I’m sick but I don’t know it and then I get my parents sick when I touch them?
- I can’t stand not knowing!

Physical feelings:

- stomach-aches
- Dizziness
- Racing heart
- Shallow breathing
- Headaches
- Muscle tension
- Shortness of breath
- Feeling detached from one’s body (derealization)

Emotions:

- Anxiety/worry/fear
- Sadness
- Anger/rage
- Shame
- Guilt

Behaviours:

- Asking parent to buy extra toilet paper or cleaning supplies
- Making parents wash their hands before making a meal
- Washing hands and body excessively
- Checking with parents that s/he didn’t make a mistake

- Repeating certain phrases in multiples of 2 or 4
- Doubting something has been done correctly
- Avoiding touching doorknobs, handles, etc.
- School or athletic performance
- Grades
- Recreational attendance and participation
- Punctuality
- Organization and focus
- Friendships
- Mealtimes
- Bedtime
- Personal hygiene

How OCD impacts the child at different ages

- It is common in toddlers, preschoolers, and even young children to have rituals and superstitions. For example, many children will eat their food in a certain order, believe and act in accordance with superstitions such as “step on a crack, break your mother’s back,” or have elaborate bedtime rituals. However, this does NOT mean the child has OCD; rather this is the child’s way of mastering new skills and exerting some control in their life. However, as children mature, we expect to see many of these “requirements” become less necessary and often disappear altogether. However, in a minority of children we see a strengthening if these “requirements” and new areas of rigid expectations crop up. A careful assessment of your child can help determine whether OCD is at play. For those diagnosed with childhood OCD, themes of harm and contamination are the most common themes in this age group.

- As children mature into adolescence the focus of OCD shifts to themes that have greater relevance to the adolescent, such as sexual and religious/moral concerns. Furthermore, because adolescent years are typically marked by a desire to “fit in" and “be normal,” those adolescents experiencing the onset of OCD may keep it a secret due to the shame and embarrassment caused by their intrusive thoughts and “strange” behaviours. Encouraging adolescents to unburden themselves by talking with an adult they trust about their OCD is a good start.

Post Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD) is a trauma- and stressor- related disorder that can develop after experiencing or witnessing a traumatic event or learning that a traumatic event has happened to a loved one.

DSM-5 defines a traumatic event as exposure to actual or threatened death, serious injury, or sexual violence. Examples may include:

- Being involved in, or witnessing, a car accident
- Undergoing major surgery (bone marrow transplant, extensive hospitalization, or severe burns)
- Experiencing or witnessing natural disasters (earthquakes, hurricanes, floods, or fire)

· Violent crimes (kidnapping, physical assault, or assault or murder of a parent or loved one)

· Community violence (attacks at school, or suicide of a friend, family member, or a child in the same-age group)

· Chronic physical or sexual abuse

· Repeated or extreme exposure to aversive details of traumatic events (PTSD does not appear to develop from watching scary movies or playing violent video games)

· Learning that traumatic event(s) occurred to a parent or caregiving figure

Following the event, youth with PTSD report intrusive symptoms such as repetitive and upsetting memories that can present verbally such as, "I can't stop hearing that crunch noise when the car hit the tree," or acted out in play such as a child repeatedly hitting a toy car against the wall. Other intrusive symptoms include distressing and vivid night and daydreams (also called flashbacks whereby the child acts as if the events is happening in real time) and becoming highly distressed when exposed to reminders of the event. Youth can also avoid or try to stay away from any reminders of the event, report inability to recall significant details of the event, experience a range of negative emotions such as sadness, guilt, shame, and confusion, and lack interest or desire to participate in important activities. Finally, children and teens with PTSD also experience irritability, being jumpy or on edge, trouble concentrating, and sleep difficulties. These combined symptoms must persist for more than a month following the event to meet the criteria for PTSD, although some children and teens may experience a delayed expression to the trauma so that clear signs are not noticeable until six months or more after the event.

Facts:

· Approximately 4% of youth aged 13-18 will develop PTSD in adolescence

· Girls are more likely than boys to develop PTSD, and to experience symptoms for a longer duration

· The chance of developing PTSD increases with the severity of the trauma. For example, almost all children who are sexually abused or who witness the death or assault of a parent will later suffer PTSD

· Youth with PTSD may experience other problems as well, including depression, other anxiety problems, or acting-out behaviors. In teens with PTSD, substance abuse problems are also common (for example, drug or alcohol use)

· The negative effects of PTSD are far reaching impacting quality of social, occupational, interpersonal, developmental, educational, and health functioning throughout the lifespan. PTSD is also associated with increased suicide risk, suicidal ideation, and suicide attempts. Timely and effective intervention is critical.

Signs & Symptoms

Thoughts (Note that very young children they may be unable to identify specific fearful thoughts):

- It's my fault it happened
- All men are dangerous
- I need to always stay alert to protect myself
- I deserved it, I'm a bad kid
- I'm a coward
- I'm not likeable and will never fit in

Physical sensations:

- Stomach-ache
- Headache
- Muscle tension
- Irritability
- Feeling amped up
- Feeling detached from one's body (derealization)

Emotions:

- Sadness
- Anger
- Shame
- Guilt
- Anxiety/fear
- Confusion
- Persistent reduction in expression of positive emotions

Behaviours:

- Avoiding participating in new activities or going places
- Avoiding people, conversations, or interpersonal situations that are reminders of the traumatic event(s)
- Refusal to sleep alone or trouble falling/staying asleep

- Hypervigilance and/or exaggerated startle response
- Asking a parent to be present or available
- Recreating the traumatic event through play
- Preoccupation with reminders of the trauma
- Crying or tantrums
- Restricted play
- Trouble concentrating
- Aggression and hostility
- Avoidance of developmental opportunities in adolescence (e.g., driving, dating)
- Common Situations or Affected Areas
- Avoiding contact with, or reminders of, the traumatic event
- Declining grades or academic failure
- Engaging in high risk, reckless, or dangerous behaviours
- Trouble making friends, dating, and development of meaningful relationships
- Restricting life plans or reduced ambition
- Social withdrawal

How PTSD impacts the child at different ages

- Children younger than age six may not have many symptoms of PTSD. Instead, they may show their anxiety in the following ways:
- Fear of strangers.
- Fear of family members.
- General avoidance of situations that are not related to the trauma (for example, avoiding going to school, going out in public).
- Traumatic play; re-enacting parts of the trauma in their play (drawings, acting out).
- Regressive behavior (thumb sucking, bed-wetting).
- Older, elementary-school-aged children with PTSD may not have symptoms of amnesia or forgetting; however, they might have some of the following symptoms:
- Omen formation. This is the belief that there were "warning signs" before the trauma occurred. Children with this belief are always on the alert for signs or warnings of "future danger". For example, if it was raining on the day of a car accident, your child might believe that the rain was a "warning" of something bad happening and refuse to leave the house when it rains.
- Traumatic play. Like very young children, elementary school children may compulsively repeat the trauma in their play. For example, a child who was traumatized by a car accident may then play with toy cars and have them crash into each other.

Adolescents with PTSD may experience many of the same symptoms as adults; however, there are a few key differences. For example, parents may notice dramatic changes in their teen, such as a teen who was once a straight "A" student is suddenly failing, or a teen who never used drugs and respected her curfew, is now dressing inappropriately, smoking, and staying out late. In addition, teens with PTSD often show increased aggressive and impulsive behaviours, and are at greater risk of engaging in high risk or reckless behaviors such as drug and alcohol use, speeding, unprotected sex, etc.