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Article

Onychophagia in Obsessive-Compulsive Disorder (OCD): Prevalence and Clinical Characterization

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Abstract

Introduction: Onychophagia, commonly known as nail biting, is a chronic and repetitive behaviour disorder characterized by a compulsive/habitual nature. Obsessive-compulsive disorder (OCD) and onychophagia present an noteworthy intersection in clinical psychiatry. With a paucity of clinical investigations on this topic, we decided to perform a study on onychophagia in OCD. **Materials and Methods:** In this cross-sectional investigation, the sample comprised patients (aged 18 years and older) having a primary diagnosis of OCD (DSM-5) and a score on the Yale-Brown Obsessive-Compulsive Scale of at least 16 (moderate OCD). Individuals were referred to the Department of Neuroscience at the University of Turin. Analysis of the data was performed using JASP (Version 0.16.3), a freely available statistical program created by the University of Amsterdam (JASP Team, 2022). Statistical value was set at $p < 0.05$. **Results:** Our sample consisted of 603 individuals with OCD and onychophagia was present in 52 of the cases, with a prevalence of 9.4%. Intriguingly, individuals with OCD and onychophagia had some specific clinical features compared to patients with OCD only. The main difference was detected in terms of the presence of autism spectrum disorder (ASD): in the group of patients having OCD and onychophagia a prevalence of ASD as high as 96.2% was identified, compared to 18.0% in the OCD without-onychophagia group. **Discussion:** Onychophagia is a relatively common problem in patients with OCD, with one individual out of ten experiencing this issue. OCD and onychophagia, when both present, might define a peculiar clinical phenotype with specific characteristics. The extremely high frequency of ASD in patients with OCD and onychophagia (96.2%) might be a very useful information for clinicians that should pay particular attention in screening for autism in this cohort of individuals.

Keywords: OCD; obsessive-compulsive; onychophagia; ASD; autism

Introduction

Onychophagia

Onychophagia, commonly known as nail biting, is a chronic and repetitive behaviour disorder characterized by the compulsive biting of one's fingernails or toenails [1,2]. It is a prevalent condition, affecting an estimated 20-30% of the population across all age groups with different degrees of severity [3,4]. The onset of nail biting typically occurs during childhood and adolescence, with the

fingernails being the most commonly affected area [1,5]. This behaviour can persist into adulthood (1–5% of population), with some individuals developing it as a habit [6].

Onychophagia is categorised in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition [7], inside the “Other Specified Obsessive-Compulsive and Related Disorders” section. The DSM-5 additionally categorises onychophagia as a recurring body-focused repetitive behaviour disorder, including lip biting and cheek chewing. The category of body-focused repetitive behaviour disorders also includes conditions such as trichotillomania (hair pulling) and excoriation (skin picking) [2,8]. These disorders are characterized by recurrent, irresistible urges to engage in self-grooming behaviours that result in physical damage [2,8]. The diagnostic criteria for onychophagia are fulfilled when patients exhibit clinically significant distress or impairment in social and occupational functioning, which cannot be more accurately attributed to trichotillomania, excoriation disorder, stereotypic movement disorder, or non-suicidal self-injury. These individuals must have made several unsuccessful efforts to inhibit their nail biting [2].

Clinically, onychophagia is marked by an inability to resist the urge to bite one’s nails, often preceded by rising tension or emotional discomfort and followed by relief or gratification. It is frequently triggered or exacerbated by stress, anxiety, boredom, or perfectionistic tendencies [9]. The clinical presentation of onychophagia can vary, with some individuals exhibiting a more severe and persistent form of the behaviour, while others may engage in nail biting intermittently [8,10]. Chronic and excessive nail biting can lead to various complications, including damage to the cuticle, permanent nail deformities, bleeding around the nail margin, and secondary bacterial infections [11,12]. This maladaptive behaviour can cause a variety of medical complications, including paronychia (inflammation of the nail fold), gingival abscesses, and increased oral bacterial colonization [1]. In severe cases, it may also result in osteomyelitis (infection of the bone) and other serious infections [13–15]. The compulsive nature of nail biting can also negatively impact an individual’s quality of life, leading to social and functional impairments [3,4,16].

Overall, onychophagia is a complex and multifaceted condition that requires a comprehensive approach to assessment and management. Increased awareness, early intervention, and a combination of behavioural and pharmacological therapies can be effective in addressing this common yet often overlooked disorder [2,3,17,18]. Precise diagnosis requires thorough history-taking and physical examination, since patients seldom arrive with nail biting or nail picking as their primary concern. The effective care of onychophagia requires both non-pharmacological and pharmaceutical interventions, needing a multidisciplinary approach that includes dermatologists, internists, paediatricians, psychiatrists, and dentists; it often involves an approach combining behavioural interventions, such as habit reversal therapy and cognitive-behavioural therapy, with pharmacological treatments when necessary [2,17,18]. Pharmacological therapies, including selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants, have been used to address the disorder [5,19]. Research has also explored the efficacy of N-acetylcysteine (NAC) as a potential treatment option for onychophagia and other BFRBs [2,20,21].

Onychophagia in Obsessive Compulsive Disorder

Obsessive-compulsive disorder and onychophagia present an interesting intersection in clinical psychiatry, highlighting the complexity of compulsive behaviours and the neurobiological mechanisms that underlie them. OCD is marked by obsessive thoughts and compulsive actions, leading to significant disruption in daily functioning across social, occupational, or other important areas due to these symptoms [22,23]. A particular subset of these compulsions includes body-focused repetitive behaviours (BFRBs) like onychophagia, which necessitates further examination regarding their prevalence, clinical implications, and treatment methodologies.

There is a paucity of clinical investigations on onychophagia in OCD. Patients exhibiting onychophagia have been found to score higher on measures of obsessive-compulsiveness, particularly those who perceive their nail biting as a significant problem [5]. Onychophagia was the second most common disorder found in a study investigating the comorbidity between OCD and

impulse-control disorders (ICDs) [24], with a current rate of 10%, right after skin-picking disorder (current rate of 12.8%). In another study, the authors showed that having OCD determined an increased risk of more than four times of having nail biting or pathological skin picking [25]. On the other end, controversy exists between reports on the two conditions, with the investigation by Pacan and colleagues (2014) [26] finding no correlation between onychophagia and OCD: among participants who bit nails during their lifetime, 5 persons (3.1%) met criteria for OCD, while in the group without onychophagia, OCD occurred in 9 persons (5.0%).

Considering the lack of studies on onychophagia in OCD, and given the high prevalence of both conditions, there is an unmet need to further elucidate the clinical and psychopathological components of this comorbidity.

Materials and Methods

Data

The data were obtained from a longitudinal observational research including individuals with OCD (Bramante et al., 2023). The sample comprised patients (aged 18 years and older) having a primary diagnosis of OCD (DSM-5) and a score on the Yale-Brown Obsessive-Compulsive Scale of at least 16 (moderate OCD). Individuals were referred to the Department of Neuroscience at the University of Turin. In this cross-sectional investigation, data were collected in in-person visits by using a semi-structured interview as per previous studies from our research group [27]. The information collected in the systematic face-to-face interview included the following areas:

- Sociodemographic information, such as age, gender, marital status, educational attainment, and employment position.
- Clinical features such as severity of Obsessive-Compulsive Disorder as measured by the Yale-Brown Obsessive Compulsive Scale Symptom Checklist.
- Psychiatric comorbidities assessed during a clinical interview by using DSM-5 (or DSM-IV equivalent) criteria and by using the Italian version of the Structured Clinical Interview for DSM-5 Axis I Disorders. Particular attention was deserved to affective disorders and obsessive-compulsive and related disorders and similar (e.g., body-focused repetitive behaviours (BFRBs)).

Ethics

All participants who engaged with our inpatient and outpatient treatments submitted written informed permission, which was approved by our ethics committee, permitting the use of their clinical data for research purposes under the condition of anonymous handling. A formal request was submitted to our ethics committee (Comitato Etico Interaziendale Azienda Ospedaliera-Universitaria San Luigi Gonzaga di Orbassano) for access to the clinical records of all patients with OCD who granted consent; the protocol received approval from the institutional ethics committee (protocol number 0007375).

Statistical Analysis

Analysis of the data was performed using JASP (Version 0.16.3), a freely available statistical program created by the University of Amsterdam (JASP Team, 2022). Assumption checks were performed to assess normality using the Shapiro-Wilk test. Paired Samples Student t-tests were used to examine variations where normality could be assumed. In cases where departures from normality were observed, the Mann-Whitney U test was adopted. Chi-Squared Test statistics was employed to detect differences on categorical variables. Statistical value was set at $p < 0.05$.

Results

Our sample consisted of 603 individuals with OCD and onychophagia was present in 52 of the cases during their lifetime, with a prevalence of 9.4% (roughly one out of ten patients with OCD had this specific behaviour). No differences were found in terms sociodemographic factors between the groups with and without onychophagia (see Table 1).

Table 1. Sociodemographic characteristics.

Variable	OCD + Onychophagia N = 52	OCD without Onychophagia N = 551	Total sample N = 603	p-value
Females - N (%)	23 (44.2)	252 (45.7)	275 (45.6)	p = 0.84
Employed - N (%)	24 (46.2)	267 (48.5)	291 (48.3)	p = 0.75
Family history of OCD - N (%)	11 (21.2)	109 (19.8)	120 (19.9)	p = 0.81
Age – mean years (SD)	32.8 (12.3)	35.3 (12.5)	35.0 (12.5)	p = 0.21
Education – mean years (SD)	13.0 (3.9)	12.7 (3.5)	12.7 (3.5)	p = 0.60

In terms of clinical characteristics, no differences were found in respect to the severity of OCD symptoms (Y-BOCS), depressives symptoms (HAM-D) and anxiety symptom (HAM-A) (see Table 2). The rates of comorbidity with Major Depressive Disorder and Anxiety Disorders were comparable among the two groups, and the duration of untreated illness (DUI) was also similar, as well as a the age at disorder onset.

Interestingly, OCD symptoms manifested earlier in patients with onychophagia compared to patients without onychophagia (15.2 years versus 16.9 years, p = 0.04). Moreover, an abrupt onset was more frequent in the onychophagia group than in the group without this specific behaviour (38.5% versus 25.8% of the samples, p = 0.04). Among all the Y-BOCS types of obsessions and compulsions, statistically significant differences between the two groups were present in regards to symmetry obsessions and repetition compulsions, with both of these specific symptoms being more common in the individuals experiencing onychophagia (see Table 2). A significant statistical difference was detected in terms of the presence of autism spectrum disorder (ASD): in the group of patients having OCD and onychophagia a prevalence of ASD of 96.2% was identified, compared to 18.0% in the OCD without onychophagia group (see Table 2).

Table 2. Selected clinical characteristics.

Variable	OCD + Onychophagia N = 52	OCD without Onychophagia N = 551	Statistic	p-value
Y-BOCS – mean score (SD)	24.3 (6.9)	(24.3 (6.2)	Mann-Whitney U test	p = 1.02
HAM-D - mean score (SD)	11.1 (6.6)	11.0 (6.4)	Mann-Whitney U test	p = 0.97
HAM-A- mean score (SD)	11.5 (6.7)	11.9 (6.6)	Mann-Whitney U test	p = 0.77
Age at OC symptoms onset – mean years (SD)	15.2 (8.7)	16.9 (8.1)	Mann-Whitney U test	p = 0.04
Age at disorder (OCD) onset – mean years (SD)	20.7 (9.3)	22.0 (8.5)	Mann-Whitney U test	p = 0.11
Duration of Untreated Illness (DUI) (OCD) – mean months (SD)	129.6 (154.0)	109.2 (116.0)	Mann-Whitney U test	p = 0.99
Type of onset				
Abrupt – N (%)	20 (38.5)	142 (25.8)	Chi-Squared Test	p = 0.04
Insidious – N (%)	32 (61.5)	409 (74.2)		
Comorbidity with MDD			Chi-Squared Test	p = 0.83

Yes - N (%)	12 (23.1)	120 (21.8)	Chi-Squared Test	p = 0.36
No - N (%)	40 (76.9)	431 (78.2)		
Comorbidity with Anxiety Disorders				
Yes - N (%)	12 (23.1)	99 (18.0)	Chi-Squared Test	p = 0.36
No - N (%)	40 (76.9)	452 (82.0)		
Comorbidity with ASD				
Yes - N (%)	50 (96.2)	99 (18.0)	Chi-Squared Test	p < 0.001
No - N (%)	2 (3.8)	452 (82.0)		
Symmetry obsessions				
Yes - N (%)	18 (34.6)	110 (20.0)	Chi-Squared Test	p = 0.01
No - N (%)	34 (65.4)	441 (80.0)		
Repetition compulsions				
Yes - N (%)	34 (65.4)	268 (48.6)	Chi-Squared Test	p = 0.02
No - N (%)	18 (34.6)	283 (51.4)		

Y-BOCS: Yale–Brown Obsessive–Compulsive Scale; HAM-D: Hamilton Rating Scale for Depression; HAM-A: Hamilton Anxiety Rating Scale; OC: obsessive-compulsive; MDD: Major Depressive Disorder; ASD: Autism Spectrum Disorder.

Discussion

Onychophagia is a relatively common problem in patients with OCD, with one individual out of ten experiencing this issue. The prevalence of Onychophagia in OCD we found is very similar to one obtained by Grant and colleagues (10%) [24].

Intriguingly, we located a very high frequency of ASD in the individuals with OCD and onychophagia (96.2%) and this might reflet a stereotypical component of the nail biting behaviour. This piece of information may be very useful for clinicians that should pay particular attention in screening patients for autistic spectrum disorder when OCD and onychophagia are both present. We could even hypothesise that onychophagia might be a clinical marker or proxy for ASD in OCD.

Moreover, individuals with the Onychophagia were characterized by symptoms such as repetition compulsions and symmetry obsessions that could be more typical of ASD than pure OCD itself.

The higher frequency of repetition compulsions in the OCD+onychophagia group is in line with the nature of pathological nail biting, which might acquire an habitual element over time. The fact that symmetry obsessions were more common in subjects with onychophagia and OCD could suggest a greater tendency toward perfectionism, need for control and routine.

Individuals with onychophagia had a reduced age at symptoms onset and a more prominent and abrupt type of disorder onset compared to the ones without. This could be in relation to the problems that arise from pathological nail biting, which could make the symptoms more evident and easy to recognize. Moreover, the consequent medical issues of this body-focused behaviour could prompt for earlier medial assistance and help-seeking, although it should be noticed that no significant differences were detected in terns of duration of untreated illness between the OCD-only group and the OCD+onychophagia group.

Therefore, it is important to bear in mind the peculiar clinical phenotype of OCD when it is in comorbidity with onychophagia.

The relationship between OCD and onychophagia could extend beyond mere symptom overlap, prompting consideration of translational and neurobiological factors. Research indicates that the neuroanatomical underpinnings of OCD involve dysfunction within cortico-striato-thalamic circuits, which are similarly implicated in the manifestation of BFRBs, including nail biting [28,29]. This neurocognitive perspective suggests that both conditions may stem from similar pathophysiological processes characterized by heightened anxiety and inadequate impulse control. Such neurobiological overlap informs an understanding that treatments effective for OCD, particularly selective serotonin reuptake inhibitors (SSRIs), may also be beneficial for those with onychophagia [19]. Recognizing

onychophagia within the context and conceptual framework of OCRDs could inform treatment protocols, indicating the importance of a multifaceted approach, including cognitive-behavioural therapy (CBT) tailored to address both the obsessions/compulsions associated with OCD and the habitual nature of onychophagia [19]. Studies showed the efficacy of behavioural therapies in reducing symptoms of onychophagia, providing evidence for positive outcomes achieved through integrative treatment modalities consisting of CBT enhanced with habit reversal training [4]. Furthermore, psychiatric interventions that include medication and have shown to reduce symptoms of OCD can also improve the habitual component of onychophagia [19]. Ultimately, addressing these interconnected issues within a unified framework could enhance therapeutic efficacy and improve patient outcomes among individuals suffering from these conditions.

Future studies, employing a longitudinal design, should be conducted to further elucidate and underpin the relationship between OCD and onychophagia. Treatment trials could be of particular use to explore possible therapeutic options for patients with this comorbidity.

In conclusion, onychophagia is a fairly common body-focused behaviour in OCD with some specific clinical features and in particular it might be a red flag for the presence of ASD in OCD.

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Conflicts of Interest: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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