Excoriation disorder: A new diagnosis in the DSM-5

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A nontechnical overview of the ACA Practice Brief on excoriation disorder is included in this article. The full Practice Brief — as well as many others on a variety of topics — is available at counseling.org/knowledge-center/center-for-counseling-practice-policy-and-research/practice-brief.

Have you ever looked in the mirror and thought, “What is this on my face?” Maybe it was a blemish, a slight imperfection or even a pimple. You may have given it little conscious thought, yet still started to pick at it ever so slightly.

But what if you couldn’t stop those picking behaviors? Let’s say that you start to experience scars, scabs and even excessive bleeding. Maybe you end up wasting large portions of your day picking at your skin, finding it more difficult to stop each time. This progresses, and you start picking more frequently and with greater intensity. Now you pick when you’re anxious or angry — or sometimes for no reason at all. One thing is certain: Once you start picking, you become stuck in a trance. You don’t even realize you’re doing it.

At first, a sense of relief, or even a “high,” may wash over you when you engage in picking behaviors. Unfortunately, feelings of guilt, embarrassment and shame flood you afterward. Beyond that, physical pain starts to ensue as a result of your picking. You become repulsed by your behaviors, attempting to conceal your scars and scabs with bandages or trying to cover your face with makeup. Furthermore, you begin to realize that you are doing all of this to yourself.

**Excoriation disorder characteristics**

Although this experience may seem foreign, odd or even outlandish, it is an all too common occurrence for individuals with excoriation disorder (ED). ED, a new diagnosis in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), is characterized by recurrent and excessive picking, scratching or rubbing of normal skin. Also known as skin-picking disorder and dermatotillomania, ED falls under the DSM-5 heading of obsessive-compulsive and related disorders because of its genetic and symptomatic connection with obsessive-compulsive disorder (OCD). Most people pick at their skin from time to time, but those with ED have an impulsive and persistent pattern of picking that progresses to the point of skin lesions and tissue damage. In most cases, these individuals feel unable to stop, and these behaviors interfere significantly with their ability to function optimally.

It is important to note that individuals with ED do not engage in picking behaviors because of a skin condition (for example, dry or itchy skin), drug or alcohol withdrawal, or another medical condition. They engage in these behaviors in an attempt to remove a perceived imperfection either on or underneath their skin. In many cases, individuals with ED will engage in picking with more frequency and intensity in response to intense emotions.

These impulses or compulsions are similar to those found in OCD. These impulses drive individuals with ED to remove an imperfection such as acne, scabs or other irregularities until the imperfection seems completely obliterated, ultimately exacerbating the imperfection. This type of skin picking is called focused picking. With focused picking, there is a building tension that leads up to the picking behaviors. Often, these individuals believe the only way to relieve their urge is to engage in the picking compulsion, similar to acting on a compulsion in OCD. Individuals who engage in this type of focused picking tend to avoid intense emotions and may pick as a means of relieving negative emotions such as sadness, worry or stress.

Although some individuals with ED are aware they are picking, others are not. When picking occurs outside of an individual’s level of awareness, the behavior is referred to as automatic picking. With automatic picking, individuals may pick while watching TV, reading or studying and may describe their picking experience as being in a trancelike state.

Individuals with ED may use their hands, mouths or even other objects such as tweezers or safety pins to pick multiple areas on their bodies (for example, face, arms, hands, chest, legs and back). In some cases, individuals eventually need antibiotics to treat infections and surgery to treat severe wounds. Additionally, this population often experiences feelings such as loss of control, embarrassment and shame regarding their behaviors. Frequently, these individuals have failed repeatedly in their attempts to decrease or stop these distressing behaviors.

Although individuals with ED often attempt to hide the physical evidence of skin picking (using bandages, clothing and makeup) from significant others, family members, friends and health professionals, these behaviors affect their social relationships and generally lead to periods of isolation. In addition to social
impulse control is defined by a tendency to engage in high-risk behaviors for pleasure-seeking purposes and without regard to the possible consequences. The pleasure an individual experiences during a picking episode is usually followed with embarrassment, guilt or shame, as is the case with most impulse-control disorders. This phenomenon can occur with both focused and automatic picking because both types can provide instant gratification. Individuals with ED may engage in both types of picking simultaneously or at different times within the same development or course of the disorder.

Individuals with ED experience a broad range of effects on functioning. These may include social impairment, such as embarrassment caused by visible lesions that may lead to isolation or avoidance of activities in which skin lesions could be exposed, and occupational impairment caused by excessive time spent picking, resulting in the neglect of job duties. Finally, lowered self-esteem may occur because of skin disfigurement or scarring, and intense frustration resulting from an inability to stop picking can lead to suicidal ideation or suicide attempts. Individuals with ED typically spend a great deal of time concealing their self-inflicted wounds and use cosmetic products, bandages or clothing to avoid questions regarding the origins of their wounds.

Unfortunately, ED is often overlooked by counselors or overshadowed by comorbid diagnoses. This is due in part to ED's recent addition to the DSM-5, its similarities and comorbidities with other disorders, the lack of publicity surrounding ED and the shame and secrecy associated with the disorder. In general, ED is highly comorbid with OCD and other body-focused repetitive behaviors such as trichotillomania. In addition, ED is often comorbid with anxiety disorders, mood disorders, impulse-control disorders and substance-related disorders.

When diagnosing ED, counselors need to differentiate the behavior from nonsuicidal self-injury (NSSI). Whereas individuals with NSSI are typically motivated by intense, negative thoughts about themselves, the world or their future, individuals with ED are more fixated on or obsessed with the removal of unwanted imperfections.

Treatment

Individuals with ED generally demonstrate some insight into their behavior and usually want to stop picking. Often, they identify large periods of time dedicated to picking, thinking about picking or trying to resist picking urges. However, frequent attempts to reduce or resist picking urges have failed, thus requiring counseling treatment.

As is the case with most mental health disorders, the sooner an individual with ED engages in treatment — preferably before having these symptoms for more than a year — the higher the likelihood of recovery. However, because ED is often overlooked by counselors, clients and society in general, many individuals are unaware that help is even available.

Because of the lack of publicity about this disorder, more research on its treatment is necessary. Even so, it is important for counselors to be mindful of this diagnosis and familiar with treatment options so that clients who suffer from ED can find relief. Cognitive behavior therapy (CBT), acceptance and commitment therapy (ACT), habit

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reversal training (HRT) and medication all appear to be effective strategies for aiding this population.

When using CBT, counselors help clients to identify, challenge and modify their distorted and dysfunctional thoughts related to their skin-picking behaviors. The first step usually consists of gathering information about the nature of the skin-picking behaviors (for example, frequency, location of picking, intensity and antecedents) and then exploring the psychoeducational component of the development and maintenance of unwanted behaviors.

Second, counselors highlight the automatic thoughts associated with these picking behaviors. For example, a client might express that because of a heated encounter with another employee, she should have the right to engage in picking behaviors. Furthermore, this client may express that relaxation is not possible without engaging in skin-picking behaviors (the client uses it as a coping mechanism). A counselor can aid this client by testing the validity of her maladaptive thoughts and attempting to replace them with more adaptive thoughts. For example, after the client’s belief is challenged, she may consider that even when she is highly upset, perhaps it is OK to feel that way and she can handle it. She may also conclude that after she picks, she feels horrible about herself, but after she takes a run on the treadmill, she feels significantly better about herself.

In addition to addressing thoughts and emotions, CBT also addresses the behaviors themselves. Three types of behavioral interventions useful with clients struggling with ED are preventive measures, activity replacement and relapse prevention. Counselors can assist clients by implementing preventive measures such as gloves, wraps or bandages to hinder and deter their ability to engage in skin-picking behaviors. These measures can also reinforce clients’ abilities to tolerate urges or serve as a distraction until urges decrease. Activity replacement helps clients to consider other, more adaptive, behaviors when their urges ensue. For example, when a client feels the urge to pick, he could consult a predetermined, practiced list of alternative behaviors (for example, cleaning, exercising or calling a friend) and substitute a more productive behavior for the picking behavior. Ultimately, after clients implement these strategies, CBT involves preparation and strategies for overcoming future urges and reducing the likelihood of relapse.

ACT is another approach to apply when working with individuals with ED. ACT integrates acceptance, mindfulness and behavioral change strategies into counseling treatment. In early stages of the counseling process, counselors help clients to distinguish between urges to pick and actual picking behaviors. Once this distinction is made, counselors can then explore clients’ past attempts to control, resist and diminish picking behaviors. These clients often believe that they cannot tolerate the tension leading to picking behaviors and engage in picking as a means to relieve these uncomfortable urges and emotions. But this proves to be only an immediate, impulsive solution because their urges ultimately return. Through mindfulness-based techniques, ACT challenges clients to instead embrace these unpleasant emotions by noticing their emotional response, attempting to tolerate these emotions in the present and ultimately engaging in more adaptive behaviors.

HRT, another approach to use when working with this population, begins with awareness training. This involves describing the picking behaviors (frequency, intensity, duration) and the specific situations that lead up to the behaviors. In essence, HRT is an approach that increases clients’ awareness of their behaviors, develops alternative responses, reinforces those responses and generalizes these new behaviors to alternative situations. For example, a competing response needs to be versatile and ready in a host of client situations. A client might decide to clench his fist for two complete minutes each time an urge arises. After two minutes, the client can assess if he has other alternatives. If not, he can clench his fist for another two minutes. This is done until his urges either are more manageable or fully dissipate. The flexibility and availability of this alternative behavior is extremely accessible and practical. It is important to have clients reinforce their adaptive behaviors by rewarding themselves when they use these behaviors. This can be done through a token economy or contingency contract that the client establishes with the aid of the counselor.

Finally, medication is another effective measure used in the treatment of ED. Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine, fluvoxamine and escitalopram are often used in the treatment of ED. This may be because SSRIs have been shown to be effective in treating OCD and related disorders such as trichotillomania. However, although SSRIs are effective for some clients, these medications have demonstrated inconsistent effects across individuals. In addition to SSRIs, clients with ED may also respond to anticonvulsant medications such as lamotrigine. Regardless of the medication used, stand-alone medication is generally not as effective as medication used in conjunction with counseling treatments.

Counselors and other mental health professionals are instrumental in advocating for the increased awareness of ED, diagnosing the disorder when necessary and providing effective counseling treatment to address clients’ difficulties. Although relapse is always a concern, through the use of a comprehensive approach to treatment, many individuals with ED lead more adaptive and productive lives.

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