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Excoriation Disorder

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DESCRIPTION OF EXCORIATION DISORDER

Excoriation disorder (colloquially referred to as skin-picking disorder) is a diagnosis newly added to fifth edition of the *Diagnostic and Statistical Manual of Mental and Emotional Disorders* (DSM-5; APA, 2013). Excoriation disorder is characterized by compulsive and obsessive skin picking behaviors which cause skin lesions and scabs. Those with excoriation disorder typically attempt to reduce the frequency of skin-picking behaviors, yet often struggle to be successful in reaching this aim without treatment (Kress, Zoldan, Adamson, & Paylo, 2015).

Excoriation disorder affects between 2-5% of the general population (Grant et al., 2012) and is more prevalent in females (APA, 2013). Those with excoriation disorder typically develop symptoms in early adolescence, and its onset usually coincides with dermatological conditions such as acne (APA, 2013). In some cases, however, people develop skin picking symptoms as late as 30 to 45 years of age (Grant et al., 2012).

Those who have excoriation disorder generally exhibit one of two types of picking behaviors (although both types can co-exist together): *automatic* or *focused* (Christenson & Mackenzie, 1994; Walther, Flessner, Conelea, & Woods, 2009). *Automatic* picking is when one engages in skin picking behaviors without awareness of this occurring (e.g., while reading or sleeping). Skin picking behaviors that are more deliberate and are used to regulate negative emotions associated with certain situations or stressors are referred to as *focused* picking.

The scars, scabs, and time spent skin-picking can lead to embarrassment, impaired functioning, and loss of control in a variety of settings (Odlaug, Chamberlain, & Grant, 2010). Those who have excoriation disorder often express guilt and shame regarding their behaviors; they often attempt to hide physical evidence of skin picking from significant others, family members, friends, and health professionals (Grant & Odlaug, 2009). The picking behaviors can affect social relationships and lead to periods of isolation (Kress et al., 2015). In addition to social impairment, those who have this disorder may experience vocational troubles as the time spent picking isolates them from their professional responsibilities.

Resources that can be useful with those who have excoriation disorder can be found at the following websites:

<http://www.skinpickingsupport.com>

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

IDENTIFICATION/ASSESSMENT STRATEGIES

When assessing for excoriation disorder, counselors should consider referring clients for a medical evaluation to rule out medical conditions that may cause or support symptoms (e.g., scabies; APA, 2013; Kress et al, 2015). Counselors should assess for comorbid disorders such as obsessive-compulsive disorder and trichotillomania (APA, 2013). In addition to skin picking and hair pulling, counselors should assess for other body-focused repetitive behaviors, which may require additional assessment and warrant attention in treatment (Grant et al., 2012). The following inventories and assessments may be helpful when assessing excoriation disorder.

Skin Picking Scale (SPS; Keuthen et al., 2001b)

The SPS is a self-report measure that explores the severity of skin picking behaviors. The SPS consists of 6 items focused on frequency of urges, intensity of urges, time spent engaging in skin picking behaviors, interference in functioning, avoidance behaviors, and overall distress. Clients rate each item on a 5-point scale (i.e., 0-4; none

to extreme) resulting in total scores between 0 and 30. The SPS can be used to aid counselors in distinguishing nuanced differences between self-injurious skin picking and non self-injurious skin picking (i.e., a score at or higher than 7 designates self-injurious skin picking behaviors).

Skin Picking Impact Scale (SPIS; Keuthen et al., 2001a)

The SPIS is a self-report measure designed to assess the consequences of repetitive skin picking (i.e., social interference and negative self-evaluation; Keuthen et al., 2001a). The measure consists of 10 items (e.g., duration of picking, satisfaction of picking, shame), which clients rate on a 6-point scale (i.e., 0-5; none to severe) resulting in a total score ranging from 0 to 60. Additionally, Keuthen and associates adapted a Skin Picking Impact Scale-Short Version (SPIS-S), which consists of only 4 questions (Snorrason et al., 2013). Both the SPIS and the SPIS-S can be used to assess similar constructs with high internal consistency and acceptable discriminate and convergent validity (Snorrason et al., 2013).

The Milwaukee Inventory for the Dimensions of Adult Skin Picking (MIDAS; Walther et al., 2009)

The MIDAS is a self-report measure designed to assess degree of focused and automatic dimensions of skin picking behaviors (Walther et al., 2009). The MIDAS consists of 21 items (e.g., I pick when I'm bored; I plan a time to pick during the day) highlighting either focused picking (e.g., reaction to negative emotions, body sensations, devices to aid picking behaviors) or automatic picking (e.g., unaware of picking, not intentional picking, concentrating on another activity; Walther et al., 2009). Each item is rated on a 5-point scale (i.e., 1-5; not true of my skin picking to always true for my skin picking), and a specific score is given for focused and automatic picking. The MIDAS has demonstrated good internal consistency and sufficient construct and discriminant validity, making it an adequate measure for distinguishing types of skin picking behaviors (Walther et al., 2009).

For a free skin picking assessment based upon the SPS and MIDAS visit:

<http://www.skinpick.com/node/3805>

The Skin Picking Impact Survey (SKIS; Tucker, Woods, Flessner, Franklin, & Franklin, 2011)

The SKIS consists of 92-items that are a combination of multiple self-report measures utilized to assess and explore skin-picking behaviors. This survey can be used to assess presentation of symptoms and severity of urges, including intensity, time spent picking, resulting distress, and avoidance. The SKIS also assesses physical and psychosocial consequences of skin picking behaviors, treatment-seeking history, and general demographic information. The SKIS can also be used to assess for comorbid disorders and associated symptoms such as depression, anxiety, and stress. Due to the number of items on this assessment tool, the SKIS may be more useful for academic or research purposes than for clinical practice (Snorrason et al., 2013).

More information about the SKIS can be found at:

<http://www.seattleimplementation.org/wp-content/uploads/2011/12/sdarticle6.pdf>

When assessing clients who have excoriation disorder, counselors should explore all aspects of clients' lives and inquire about recent life experiences, past traumas, and current life stressors (LaBrot, Dufrene, Ness, & Mitchell, 2014). Current life stressors may exacerbate excoriation disorder, and professional counselors may suggest self-monitoring skin picking behaviors during the week following the initial session to better understand frequency, triggers, cues, and changes in frequency of behaviors.

INTERVENTION STRATEGIES

Few randomized controlled research studies exist, yet there are a number of treatment options that seem promising for counselors who counsel those who have excoriation disorder. Treatment options include cognitive-behavioral therapy, habit reversal training, acceptance and commitment therapy, and pharmacotherapy (Flessner, Busch, Heideman, & Woods, 2008; Grant et al., 2012; Kress et al., 2015; Teng, Woods, & Twohig, 2006).

Resources for more information on treatment options visit:

<http://www.trich.org/about/skin-treatment.html>

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) is an effective strategy for working with clients who have excoriation disorder (Grant et al., 2012; Schuck, Keijsers, & Rinck, 2011). The essential components of CBT for those with excoriation disorder consist of identifying, challenging, and modifying clients' distorted and dysfunctional thoughts related to their skin picking behaviors (Schuck et al., 2011). Excoriation disorder protocols not only address thoughts and emotions, but also behaviors. Three types of behavioral interventions that can be useful include preventative measures, activity replacement, and relapse prevention (Kress et al., 2015). Counselors can aid clients by implementing preventative measures (e.g., gloves, wraps, or bandages) to hinder the ability to engage in skin picking behaviors. Additionally, these measures can be used to reinforce clients' abilities to tolerate urges or as a means of distraction until urges decrease. After implementing these strategies, CBT ultimately addresses preparation and strategies for overcoming future urges and relapse prevention.

Resources for additional information on utilizing CBT with those with excoriation disorder:

<http://www.ocdla.com/compulsiveskinpicking.html>

<http://www.beckinstitute.org/cognitive-behavioral-therapy/>

Habit Reversal Training

Habit reversal training (HRT) is a behavioral approach aimed at increasing clients' awareness and alleviating the occurrence of skin picking. The primary goal of HRT is to assist clients in the intentional replacement of skin picking behaviors with alternative adaptive behaviors (Grant et al., 2012; Snorrason & Bjorgvinsson, 2012; Teng et al., 2006). Those with excoriation disorder are first challenged to develop awareness of skin picking behaviors and responses (e.g., when, how often, how long, warning signs, patterns of behaviors). The warning signs are then discussed with the client (e.g., "I tend to pick the back of my arms when I feel anxiety come on"). Next, the client can explore and consider a competing response to warning signs and/or picking behaviors. For example, clients can hold their hands together for a five count and then continue as necessary. Replacing one activity with another can aid clients in increased awareness and ability to suppress or replace skin picking behaviors (Teng et al., 2006). Finally, clients can implement these competing responses outside of session, and eventually, apply them to new behaviors (Teng et al., 2006).

Acceptance and Commitment Therapy

Acceptance and commitment therapy (ACT) is based on mindfulness techniques that teach acceptance of negative thoughts and emotions, and then combine behavior-change techniques to address unhealthy behaviors (Flessner et al., 2008). Initially, the counselor helps the client investigate previous attempts to curb skin picking behavior (e.g., avoidance or relaxation while picking). Then, the client and counselor work to distinguish between thoughts, feelings, and sensations associated with urges to pick and actual skin picking. Although this is only a short-term solution as the urges eventually return, professional counselors should use metaphors to emphasize that the most effective way to remove urges is to act immediately with alternative behaviors (Flessner et al., 2008).

Next, professional counselors using ACT should highlight clients' inability to control the situation, which eventually leads to change of clients' thoughts and feelings associated with urges to pick. Together, the client and counselor address six processes which contribute to healthy, flexible living (i.e., the "hexaflex" model): (a) present-moment awareness; (b) acceptance rather than avoidance; (c) self-as-context (awareness of thoughts without attachment to them); (d) values identification; (e) cognitive diffusion (reduce judgment of thoughts rather than reducing unhelpful thoughts); (f) committed action with short- and long-term behavioral goals (Flessner et al., 2008). Lastly, treatment progress is reviewed, and the client and therapist engage in relapse prevention planning.

Pharmacotherapy

Although selective serotonin reuptake inhibitors (SSRI) such as Prozac have been found effective in treating excoriation disorder and other body-focused repetitive behaviors (BFRB), this effect has not been consistent across clients (Grant et al., 2012; Grant & Odlaug, 2009). Professional counselors should ensure that other mental health interventions (e.g., CBT, HRT, ACT) are used in conjunction with any pharmacotherapy. Pharmacotherapy interventions for excoriation disorder should be used with caution, and further exploration of the link between skin picking and other body-focused repetitive behaviors is warranted (Grant & Odlaug, 2009).

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