

Excoriation Disorder: Assessment, Diagnosis and Treatment



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Excoriation disorder (also called skin picking disorder) is a newly added, often overlooked mental disorder in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2013). The purpose of this article is to increase professional counselors' abilities to recognize and effectively address the symptoms of excoriation disorder. In this article, the etiologies, diagnostic criteria and assessment strategies for excoriation disorder are described. Excoriation disorder develops as the result of biological and physical contributors and might serve to regulate emotions. A review is provided of specific interventions and treatments, such as cognitive behavioral therapy and acceptance and commitment therapy, which have demonstrated success in treating those who have excoriation disorder.

Keywords: excoriation disorder, skin picking, assessment, diagnosis, DSM-5

Excoriation disorder, sometimes colloquially referred to as skin picking disorder, is a newly added disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013). Despite being a newly-classified DSM disorder, excoriation disorder is relatively common and affects between 1.4 and 5.4% of the general population (Grant et al., 2012). The purpose of this article is to provide professional counselors with a general understanding of how to assess, diagnose and treat excoriation disorder.

The prevalence of excoriation disorder may be underestimated, as it is sometimes overlooked, particularly because of comorbidity with other mental disorders (e.g., depression, anxiety, obsessive-compulsive disorder; Hayes, Storch, & Berlanga, 2009). Previously underestimated numbers of its prevalence also may be due to the covertness often associated with this disorder (Grant & Odlaug, 2009). Many people with excoriation disorder go to great lengths to hide their behavior from others (e.g., significant others, family members, health professionals) due to fear or embarrassment.

Historically, excoriation disorder has been associated with obsessive-compulsive disorder (OCD), and it is now listed as a unique diagnosis in the *obsessive-compulsive and related disorders* section in the DSM-5 (Ravindran, da Silva, Ravindran, Richter, & Rector, 2009). According to the APA (2013), excoriation disorder involves the recurrent, excessive and often impulsive scratching, rubbing and picking of skin which leads to tissue damage and lesions. Those who have excoriation disorder frequently initiate attempts to eradicate these destructive behaviors, yet have difficulty doing so. In order for the diagnosis of excoriation disorder to be applied, individuals must experience clinically-significant distress or impairment in social, occupational or other important areas of functioning due to the routine nature of the skin picking behaviors (APA, 2013). Because of its physical manifestation, this phenomenon has frequently been discussed in medical research, but it is now receiving attention in mental health circles.

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Etiology of Excoriation Disorder

Little is known about the etiology of excoriation disorder. Much of the current excoriation disorder research has been based on previous research conducted on trichotillomania. Excoriation disorder and trichotillomania are body-focused repetitive behaviors (BFRB) under the same *DSM-5* classification, and the etiologies behind both disorders might be similar (Flessner, Berman, Garcia, Freeman, & Leonard, 2009). Most theorists suggest that excoriation disorder is rooted in both biological and psychological factors (Grant et al., 2012).

Biological factors related to excoriation disorder include genetic predispositions and neurological sensitivity to emotional stimuli, which result in emotional impulsivity and a need to self-soothe (Snorrason, Smári, & Ólafsson, 2011). In one study of 40 individuals who had excoriation disorder, 43% had a first-degree relative with the disorder (Neziroglu, Rabinowitz, Breytman, & Jacofsky, 2008). Specific genes (e.g., *Hoxb8* and *SAPAP3*) have been identified as potential predictors of this disorder (Grant et al., 2012). In animal studies, mice with these genes engaged in excessive grooming to the point of skin lesions, behaviors similar to those of people who have excoriation disorder (Grant et al., 2012). Conversely, in another study, humans with the *SAPAP3* gene only met criteria for excoriation disorder 20% of the time (Dufour et al., 2010). It is important to note that genetics appear to play a role in the development of excoriation disorder, but other factors contribute to the disorder's etiology and maintenance as well (Grant et al., 2012; Lang et al., 2010).

In terms of psychological factors, skin picking behaviors help regulate uncomfortable emotions and can become a behaviorally-reinforced coping mechanism used to manage negative feelings (Lang et al., 2010). Some researchers suggest that excoriation disorder is rooted in higher levels of emotional impulsivity and that this characteristic supports and encourages the development of the disorder (Grant et al., 2012). Those with excoriation disorder experience obsessive thoughts about skin picking and engage in more impulsive, sensation-seeking behaviors (e.g., picking, rubbing) than those without the disorder (Snorrason et al., 2011). Those with excoriation disorder often have a greater difficulty with response inhibition and an increased difficulty suppressing an already initiated response as compared to control participants (Grant, Odlaug, & Chamberlain, 2011; Odlaug & Grant, 2010). For example, it might be more difficult for those with excoriation disorder to retract their hand if they already started reaching for an object to use to excoriate. This elevated level of impulsivity may be rooted in brain abnormalities; however, further research is necessary to clearly establish this connection (Grant et al., 2012).

Another common theory regarding the onset and maintenance of excoriation disorder is that skin picking behaviors can help regulate emotions and can become a behaviorally-reinforced coping mechanism used to manage elevated levels of anxiety, stress and arousal. Individuals who skin pick often display elevated stress responses to normal stimuli (Lang et al., 2010), and skin picking appears to temporarily sooth such stress. Additionally, obsessive thoughts about skin imperfections and anxiety over not picking can be temporarily relieved by completing the behaviors (Capriotti, Ely, Snorrason, & Woods, 2015). As such, there is a behavioral component—in addition to the genetic and biological components of the disorder—that must be considered when understanding the etiology, assessment, diagnosis and treatment of excoriation disorder.

Assessment and Diagnosis of Excoriation Disorder

The proposed etiologies (e.g., genetic predispositions, biological markers) and functions (e.g.,

soothing emotional reactivity, reducing obsessive thoughts) of excoriation disorder inform the diagnostic and assessment process. It is important that counselors have a thorough understanding of the *DSM-5* criteria for excoriation disorder and understand that many clients with this disorder might hide physical markers and omit skin picking information unless asked directly (Grant & Odlaug, 2009). As such, counselors might use formal assessments, in addition to clinical judgment, in order to make an accurate diagnosis and best understand the client's behaviors.

Assessment

A number of assessment tools can be used to assist in assessing, diagnosing and treating those who have excoriation disorder. Each measure can be utilized by counselors in developing a holistic conceptualization of the client and for engaging in differential diagnosis. Upon accurate diagnosis of excoriation disorder, assessment measures also can aid counselors in selecting appropriate treatment goals, interventions and modalities for each client, and they can be used to assess client behavior change.

Keuthen et al. (2001b) constructed three skin picking scales that can be used to assess excoriation disorder and aid in the assessment and treatment process. The first measure, the Skin Picking Scale (SPS), can be used to measure the client's self-reported severity of skin picking behaviors. This measure consists of six items that relate to the frequency of picking urges, intensity of picking urges, time spent engaging in skin picking behaviors, interference of the behaviors in functioning, avoidance behaviors and the overall distress associated with the excoriation-related behaviors. Each item is assessed on a 5-point scale of 0 (none) to 4 (extreme), resulting in a range of total scores between 0 and 24. The SPS demonstrated high internal consistency with adequate convergent validity (Keuthen et al., 2001a). Pragmatically, this measure can be used to distinguish self-injurious skin picking from non-self-injurious skin picking. As treatment gains are made, corresponding scores should decrease.

The second measure is the Skin Picking Impact Scale (SPIS). The SPIS is a self-report questionnaire designed to assess the impacts or consequences of repetitive skin picking (e.g., negative self-evaluation, social interference; Keuthen et al., 2001a). Each of the scale's 10 items are rated on a 6-point scale from 0 (none) to 5 (severe), resulting in a total score ranging from 0 to 50. The SPIS has high internal consistency (Keuthen et al., 2001a; Snorrason et al., 2013), and scores appear to correlate with duration of picking, satisfaction of picking and shame associated with picking.

The third measure is the Skin Picking Impact Scale-Shorter Version (SPIS-S). The SPIS-S is the shorter version of the SPIS consisting of only a 4-question scale (Snorrason et al., 2013). The SPIS and the SPIS-S have a similar factor structure and both have high internal consistency. These measures assess the impacts of picking behaviors on social life, perceived embarrassment associated with picking behaviors, consequences of picking behaviors and perception of attractiveness (Snorrason et al., 2013). The ultimate difference between the two scales is the brevity of the shorter version measure as compared to 10 items on the other measure. Snorrason and associates (2013) found acceptable discriminant and convergent validity for the SPIS and the SPIS-S; both measures may be considered for clinical use.

The Milwaukee Inventory for the Dimensions of Adult Skin Picking (MIDAS) is another skin picking assessment measure (Walther, Flessner, Conelea, & Woods, 2009). The MIDAS consists of 21 items and highlights the degree of *focused* picking (e.g., body sensations, reaction to negative emotions) and *automatic* picking behaviors (e.g., unaware of skin picking behaviors, concentrating on another activity, unintentional picking; Walther et al., 2009). Within the measure, 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 provided for *focused* and *automatic* picking. The MIDAS demonstrates adequate internal consistency and good validity (i.e., construct and discriminant), making it a reliable and valid measure for distinguishing types of skin picking behaviors (Walther et al., 2009). This assessment is especially useful in facilitating an understanding of the client's motivations for skin picking, as well as potential ways to reduce the problematic behaviors.

The Skin Picking Impact Survey (SKIS; Tucker, Woods, Flessner, Franklin, & Franklin, 2011) is a self-report survey measure. The SKIS, which consists of 92 items, is used to explore multiple dimensions of skin picking behaviors. This survey consists of individual items that assess skin picking symptoms (e.g., presentation), levels of severity (e.g., urges, intensity, time spent, distress, avoidance), consequences (i.e., physical and psychosocial), treatment-seeking history, and demographic information. The SKIS demonstrated acceptable internal consistency (Tucker et al., 2011). Additional items are used to assess for comorbid disorders and other associated symptoms (e.g., depression, anxiety, stress).

Finally, a unique approach to assessing excoriation disorder is to utilize a functional analysis assessment (LaBrot, Dufrene, Ness, & Mitchell, 2014). Although not created primarily to assess skin picking behaviors, a functional analysis assessment is a behavioral technique used to explore the relationship between any stimuli and response (e.g., being cold and shivering; LaBrot et al., 2014). With regards to excoriation disorder, the functional analysis assessment consists of behavior scales and individual interviews with anyone close to the client (e.g., spouse, family member, classroom teacher). The interviews include a discussion of the client's behaviors and antecedents to such behaviors (LaBrot et al., 2014). This interview also involves a direct observation of the client in the most problematic setting (e.g., home, work, school), and counselors should take note of the time of day or events that often lead up to skin picking behaviors.

A functional analysis assessment also might involve the use of a thought log to help explore thoughts that lead to skin picking behaviors (LaBrot et al., 2014). This connection between thoughts (i.e., obsessions) and behaviors (i.e., compulsions) is characteristic of the obsessive-compulsive *DSM-5* classification under which excoriation disorder is housed. Counselors may suggest that clients self-monitor their skin picking behaviors in order to better understand the frequency, triggers, cues, and increases or reductions in thoughts and behaviors. For example, clients may be asked to place a journal or worksheet in places where picking often occurs (e.g., bathroom, bedroom) and then to report and rate the intensity of urges, precipitating events, alternative behaviors, and if picking behaviors actually occurred. When assessing skin picking, clients also should be invited to note any attempts to stop picking, consequences of the skin picking behaviors, and other behaviors that could potentially serve as incompatible replacements (LaBrot et al., 2014). The use of a functional analysis assessment allows the counselor to gain a more complete, contextual picture of the behaviors.

To gain a richer understanding of the client's behaviors, counselors might (if approved by the client) gather assessment and baseline information from the client's friends and family members (Grant & Stein, 2014). During the assessment process, counselors should explore all aspects of the client's life, including recent life experiences, past traumas and current life stressors (LaBrot et al., 2014). An accurate diagnosis and collaborative treatment plan can be developed when this information is integrated to form a contextual understanding of the client's skin picking experiences.

Diagnosis

A thorough assessment helps counselors to identify an accurate diagnosis. Armed with assessment data, counselors can determine the presence of excoriation disorder and any comorbid disorders. In

order to accurately diagnose the disorder, counselors must be familiar with the *DSM-5* diagnostic criteria and understand diagnostic considerations related to the disorder.

The onset of excoriation disorder varies significantly, but it most often begins in early adolescence or between the ages of 30 to 45 years old (Grant et al., 2012). Skin picking causes physical harm, and clients often make repeated attempts to reduce the behavior because of the distress and physical impairment it invites. By definition, excoriation disorder is not caused by a substance or medical condition and not accounted for by another disorder (APA, 2013). The diagnostic features of excoriation disorder remain the same regardless of age or other multicultural factors (Grant et al., 2012). The general features that a counselor should look for when diagnosing excoriation disorder include a preoccupation with picking behaviors, difficulty in controlling the behaviors and distress resulting from the behaviors.

Because this is a newer diagnosis, it is often overlooked, misdiagnosed (Grant et al., 2012), or overshadowed by comorbid diagnoses (APA, 2013; Grant & Stein, 2014; Hayes et al., 2009). It is important to distinguish between excoriation disorder and nonsuicidal self-injury, both of which involve self-inflicted damage to the body that provides relief from unwanted thoughts or feelings (APA, 2013). Nonsuicidal self-injury is typically motivated by negative thoughts or feelings about the self in relation to others, and bodily harm provides a feeling of relief or euphoria (APA, 2013; Shapiro, 2008). Conversely, excoriation disorder is an obsessive-compulsive and related disorder and is more ritualistic; unwanted thoughts and feelings are directly related to bumps or certain types of scabs on the body, and clients have a routine related to removal (e.g., examining, picking) and disposal (e.g., playing with or eating) of such bumps or scabs (APA, 2013; Capriotti et al., 2015; Walther et al., 2009).

Individuals with excoriation disorder generally have difficulty resisting the urge to pick and often believe their behavior cannot be altered or changed (Kress & Paylo, 2015). Typically, there are two types of picking behaviors: behaviors that are *automatic* and behaviors that are *focused* (Christenson & Mackenzie, 1994). Individuals who engage in picking behavior outside of their awareness, such as while watching television or while reading a book, are engaging in what is known as *automatic* picking. Those who are fully aware of their behavior and pick to regulate or to manage negative emotions due to specific thoughts or stressors are engaging in *focused* picking. Both types of picking typically cause client embarrassment, impair functioning and are difficult to manage and control (Odlaug, Chamberlain, & Grant, 2010).

Although focused skin picking might seem to be more directly tied to conscious obsessions than the automatic type, both types were reclassified under obsessive-compulsive and related disorders in the *DSM-5* due to the universal obsessive and compulsive features of the disorder; these obsessions and compulsions also are shared with individuals who have trichotillomania (Snorrason, Belleau, & Woods, 2012) and body dysmorphic disorder (Tucker et al., 2011). In each of these disorders, obsessions lead to an overwhelming urge to act upon unhelpful thoughts, which is often followed by a brief sense of relief once the compulsion has been engaged and completed. However, the urge inevitably arises again (despite bodily damage and some potential shame), and the cycle continues.

Ultimately, excoriation disorder is characterized by recurrent and excessive tissue damage that is not better accounted for by nonsuicidal self-injury. Those who have excoriation disorder have difficulty controlling their picking behaviors and experience clinically significant distress or impairment as a result of these behaviors (APA, 2013). Assessment measures can be used in conjunction with the *DSM-5* in order to make an accurate diagnosis that can inform clients' treatment.

Treatment of Excoriation Disorder

Several evidence-based treatment options are available for use in treating those who have excoriation disorder (Kress & Paylo, 2015). Unfortunately, many providers fail to use evidence-based treatment approaches in their work with this population (Tucker et al., 2011). A relatively small number of randomized controlled treatment studies have been conducted on this population; however, the most evidence-based approaches include cognitive behavioral therapy, habit reversal training and pharmacotherapy (Capriotti et al., 2015; Kress & Paylo, 2015).

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). Schuck et al. (2011) conducted a randomized study of college-age students who reported pathological skin picking; participants were provided four sessions of CBT and compared to those on a waitlist. These researchers observed a significant decrease in psychosocial impact of skin picking, severity of skin picking and perceived strength of skin picking cognitions in the group randomly assigned to the four sessions of CBT. These treatment effects were maintained at a two-month follow-up, thus suggesting that CBT is effective in reducing the severity of symptoms, effect of symptoms and dysfunctional cognitions associated with excoriation disorder.

Practically, CBT for clients with excoriation disorder is focused on using cognitive restructuring to counter dysfunctional thoughts (Schuck et al., 2011). Before engaging in CBT techniques, a counselor should ascertain the nature and location of the picking and provide clients with psychoeducation regarding the etiological and maintenance factors related to their disorder. Socratic questioning is one CBT technique used to help clients recognize their fundamental beliefs and automatic thoughts surrounding skin picking (Kress & Paylo, 2015). When applying this technique, the counselor generates a hypothesis about the client's thoughts (that lead to skin picking), but leads the client to the information rather than suggesting it. The client is led to insight through a series of questions regarding the topic of interest. For example, the counselor might believe that a client's skin picking obsessions become stronger when personal and professional obligations become overwhelming. The counselor might ask, "What feelings do you have when picking? What time of day do you typically pick? Are there ever days when you do not pick?" The counselor would use reflections to organize and expand upon the client's responses until they gain new insight about their thoughts, patterns and beliefs regarding this behavior.

When using CBT, irrational thoughts are examined for validity and replaced with more rational thoughts and behaviors (Kress & Paylo, 2015). For example, an individual tempted to engage in skin picking after an argument with a spouse would challenge the need to pick with more rational thoughts, such as, "Even if I become anxious, I can tolerate the anxiety. Instead of picking, I can clean the house or exercise." This type of change occurs over a period of time, and counselors and clients should celebrate small victories, such as delayed or reduced skin picking, as the more rational thoughts begin to become more salient.

CBT not only involves cognitive interventions, but also includes behavioral interventions such as homework, preventative measures, activity replacement and relapse prevention (Capriotti et al., 2015; Kress & Paylo, 2015; Schuck et al., 2011). Counselors may assign homework such as CBT thought logs to help clients track picking behaviors. While reviewing the logs in session, counselors can assist clients in developing preventative measures, such as wearing gloves or bandages to hinder skin

picking, and activity replacement such as reading a book, cleaning or watching television instead of skin picking. CBT also places a heavy emphasis on relapse prevention, or the preparation to prevent future urges to pick.

Habit Reversal Training

Habit reversal training (HRT) is an effective strategy for working with clients who have excoriation disorder (Capriotti et al., 2015; Grant et al., 2012; Teng, Woods, & Twohig, 2006). HRT is a behavioral approach that involves helping clients gain awareness of their skin picking and then replace the picking with more adaptive behaviors (Grant et al., 2012; Ravindran et al., 2009; Snorrason & Bjorgvinsson, 2012; Teng et al., 2006). The first step of treatment is awareness training, which helps clients who are often unaware of their skin picking to associate factors, such as time of day and specific situations, to skin picking behavior (Teng et al., 2006). To facilitate this awareness, a counselor may point out in-session skin picking behavior. After developing an awareness of antecedent situations (i.e., the situations that precede picking incidents), the counselor and client collaboratively develop a competing response, or another behavior that is inconsistent with skin picking, to substitute for the skin picking behaviors (Teng et al. 2006). An example of an alternative behavior would be clenching one's fist each time a client notices that he or she is picking. This competing response, which should be one that is easily applicable in a number of situations, diminishes the urge or reduces its intensity.

The next step in HRT is the establishment of a contingency management system or token economy involving rewards and punishments. This type of treatment approach allows the clients' behaviors to be rewarded as they make successive approximations toward the goal. Rewards and punishments must be meaningful to clients, and they also must be specific and timely. At first, rewards are extrinsic, such as verbal praise or toys with children. As target behaviors are reached (e.g., reduced skin picking), clients begin to access more intrinsic reinforcers (e.g., an increased sense of self-esteem, feelings of belonging within the community/society). Finally, clients are coached to consistently implement these operant conditioning strategies outside of session and to eventually apply them to new behaviors (Capriotti et al., 2015; Teng et al., 2006). The client gradually realizes that skin picking is not a necessary coping skill, as other, more adaptive behaviors can be used to effectively reduce stress.

Teng et al. (2006) conducted a controlled study in which they compared HRT treatment to a waitlist control group. These researchers demonstrated a significant reduction in skin picking behaviors at the termination of treatment and upon follow-up assessment, as compared to the control group. The research on HRT suggests that it is a promising approach for use with those who have excoriation disorder.

Acceptance and Commitment Therapy

Acceptance and commitment therapy (ACT), when used in conjunction with HRT, demonstrates clinical promise in treating those who have excoriation disorder (Capriotti et al., 2015; Flessner, Busch, Heideman, & Woods, 2008). Capriotti et al. (2015), through the use of multiple clinical case studies, demonstrated that Acceptance-Enhanced Behavioral Therapy (i.e., ACT plus HRT) decreased excoriation symptomology in three of four participants in their case study research. These results support the findings of a similar case study done by Flessner et al. (2008), which demonstrated decreased symptomatology of excoriation disorder when ACT was incorporated with HRT.

ACT uses mindfulness techniques to teach acceptance of negative thoughts and emotions and then combines behavior-change techniques to address unhealthy behaviors (Flessner et al., 2008). Initially,

the counselor helps the client investigate previous attempts to curb skin picking behaviors (such as avoidance or relaxation while picking). Then, the client and counselor work to distinguish between urges to pick (i.e., thoughts, feelings, sensations) and actual skin picking, emphasizing that even if urges are acted upon, they will soon return. As such, the focus is on increased distress tolerance and acceptance of urges (Kress & Paylo, 2015). The difficulty of controlling urges can be illustrated through metaphors in which the client gains control and a position of power over an undesirable, yet steadfast external circumstance (e.g., working is unavoidable, but you can find a job you enjoy).

Next, using ACT treatment, the client's ability to control his or her own thoughts and behaviors is highlighted. This emphasis on controlling behavior stands in contrast to most clients' natural inclination to focus on controlling or avoiding external situations. Next, the counselor and client work to modify and change the thoughts and feelings associated with urges to pick (Flessner et al., 2008). The client and counselor address six processes that contribute to healthy, flexible living: present-moment awareness; acceptance (as opposed to avoidance); nonjudgmental awareness of one's thoughts; values clarification; changing, rather than reducing, unhelpful thoughts; and short- and long-term behavioral goals. Lastly, treatment progress is reviewed, and the client and counselor engage in relapse management (Flessner et al., 2008; Twohig, Hayes, & Masuda, 2006). Counselors also can integrate medication management when therapeutically indicated.

Pharmacotherapy

If pharmacotherapy is used to treat excoriation disorder, it should be used in conjunction with counseling; medication can control physical symptoms, but contributing mental health factors must be addressed in order to holistically help the client make enduring behavior changes (Grant et al., 2012). Selective serotonin reuptake inhibitors, specifically Fluoxetine (Prozac), have been shown to be effective in treating excoriation disorder and other BFRB (Grant et al., 2012; Simeon et al., 1997). However, this effect has not been consistent across clients (Grant & Odlaug, 2009). Therefore, additional research on the effectiveness of medication is needed. Counselors should provide intentional treatments for clients while taking into account unique client considerations.

Special Considerations

Although those with excoriation disorder might go to great efforts to conceal their wounds from others (Grant & Odlaug, 2009), they are likely to admit to skin picking behaviors when effectively questioned by a mental health professional (APA, 2013). It is important to ensure the clients with excoriation disorder are physically well (i.e., free from medical complications associated with picking), and a referral to medical professionals to ensure physical safety and appropriate medical care may be necessary (Grant et al., 2012).

Excoriation disorder occurs more often in those who also have OCD (APA, 2013). Several additional disorders are often found to be comorbid with excoriation disorder, including trichotillomania, major depressive disorder, anxiety, psychotic disorders, neurodevelopmental disorders and factitious disorder (APA, 2013; Hayes et al., 2009). Picking behaviors also could be due to a general medical condition or substance use (e.g., such as with methamphetamine addictions), and these should be ruled out (APA, 2013).

Those with first-degree family members who have excoriation disorder are more likely to also develop skin picking behaviors (APA, 2013). However, skin picking often begins during puberty, and the onset is often associated with the development of skin irregularities (e.g., acne; APA, 2013, Tucker et al., 2011). It was found that approximately 87% of college-aged students in Turkey who had acne or

other skin blemishes displayed some skin picking behaviors, but only about 2% reported clinically-significant symptoms of excoriation disorder (Calikusu, Kucukgoncu, Tecer, & Bestepe, 2012). The aforementioned finding suggests that dermatological factors, such as acne, might explain the onset of excoriation disorder, but not necessarily the maintenance of such behaviors. As such, family history of such behaviors should be considered by counselors when assessing and treating this disorder.

Collaborative relationships with other professionals can be helpful when working with a client who has excoriation disorder. If clients are provided with psychopharmaceutical interventions, counselors should take care to communicate with the prescribing physician in order to help the client maintain proper medication schedules and to potentially provide psychoeducational support to the client (Grant et al., 2012). Although consultation with a dermatologist is not always necessary, this valuable resource should be integrated into treatment when possible, and open communication can ensure that clients are receiving the support that they need (Calikusu et al., 2012; Grant et al., 2012).

Finally, although excoriation disorder is now an official *DSM* diagnosis, the research literature on effective treatments is still in its infancy stage (Capriotti et al., 2015). Additional research also is needed to determine the prognosis of excoriation disorder. As previously indicated, researchers have found psychopharmaceutical and cognitive behavioral interventions to be promising (Flessner et al., 2008; Grant et al., 2012; Schuck, et al., 2011; Simeon et al., 1997), but additional outcome research still needs to be conducted on this disorder (Capriotti et al., 2015). Further research on this new *DSM-5* disorder will provide more concrete information regarding assessment and treatment options for this population.

Summary

The etiology of excoriation disorder is still being explored, and several theories are currently supported as viable options. Both biological and psychological factors appear to contribute to the development and maintenance of this disorder (Grant et al., 2012). Skin picking behaviors are often found in those who have higher levels of emotional impulsivity, and these behaviors might serve as a way for individuals to regulate their emotions.

There are several formal measures that can be used to aid in the assessment and diagnosis of excoriation disorder. In addition to formal quantitative measures, the functional analysis assessment is a helpful method that can be used to increase both the client's and the counselor's understanding of the behaviors (LaBrot et al., 2014). Regardless of the assessment procedures employed, counselors should explore all aspects of the client's life in order to create a comprehensive treatment approach.

Since excoriation disorder is a new diagnosis in the *DSM-5*, it is often overlooked or misdiagnosed. Counselors should fully assess a client's presenting concerns in order to determine an accurate and helpful diagnosis. Counselors also should note that this disorder is often comorbid with other mental disorders (APA, 2013; Grant et al., 2011; Hayes et al., 2009).

In terms of the treatment of excoriation disorder, CBT is one of the more evidence-based approaches (Grant et al., 2012; Schuck et al., 2011), as is HRT (Grant et al., 2012; Teng et al., 2006). ACT has been used with success with HRT (Capriotti et al., 2015; Flessner et al., 2008). Psychopharmacotherapy also holds promise as an effective adjunct to psychosocial treatments (Grant et al., 2012; Simeon et al., 1997).

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