OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

Excoriation (Skin-Picking) Disorder

SPD

DSM-5-TR 698.4 | ICD-10-CM L98.1

Recurrent skin picking causing lesions and scarring, with repeated failed attempts to stop despite medical and social cost.

LIFETIME PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~1.4-5.4% of adults	Adolescence, often with acne	~3:1 female:male	Chronic, waxing and waning

CLINICAL PICTURE

- The face, arms, and hands are the most commonly picked sites, with patients targeting acne, scabs, calluses, or perceived irregularities.
- Picking is done with fingernails, tweezers, pins, or teeth, and usually follows scanning the skin by touch or in a magnifying mirror.
- Episodes may last hours and occur in automatic or focused modes, most often at night or during sedentary screen time and driving.
- Sequelae include local infection, scarring, disfigurement, and rarely septicemia requiring antibiotics or surgical debridement.
- Patients camouflage with makeup, long sleeves, and bandages, and avoid beaches, gyms, locker rooms, and physical intimacy.
- Presentation is typically to dermatology, and direct questioning is required because patients rarely disclose the behavior spontaneously.

DIAGNOSTIC CRITERIA AT A GLANCE

- Recurrent skin picking that results in visible skin lesions, occurring repeatedly over time rather than in isolated or provoked episodes.
- Repeated attempts to decrease or stop the picking, reflecting loss of behavioral control rather than a benign grooming habit.
- The picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Not attributable to a substance such as cocaine or methamphetamine, and not attributable to a dermatologic or other medical condition.
- Not better explained by another disorder, including BDD, delusional parasitosis, stereotypic movement disorder, or nonsuicidal self-injury.

NEUROBIOLOGY & PHYSIOLOGY

- Shares habit-formation circuitry with trichotillomania, involving dorsal striatum, motor cortex, and impaired stop-signal response inhibition.
- Glutamatergic dysregulation supports **N-acetylcysteine 1200-3000 mg/day**, which outperformed placebo in a randomized 12-week trial.
- SAPAP3 knockout mice display compulsive self-grooming with facial lesions that respond to fluoxetine, providing a translational model.
- First-degree relatives show elevated rates of body-focused repetitive behaviors, supporting substantial familial transmission of risk.
- Opioid-mediated reward may contribute, and **naltrexone 50 mg/day** has case-level support when patients describe picking as pleasurable.
- Frequent onset during adolescent acne links dermatologic trigger stimuli to acquisition of the habit during a high-plasticity period.

PSYCHOLOGICAL MECHANISMS

- Automatic picking is negatively reinforced by removal of tactile irregularity and tension, while focused picking regulates anxiety, boredom, or anger.
- Perfectionistic beliefs about smooth, flawless skin drive scanning behaviors that themselves generate the cues for the next episode.
- Mirrors, bright bathroom lighting, idle hands, and prolonged sitting function as reliable and predictable external triggers.
- Shame about visible lesions produces avoidance and social withdrawal, which further reduces competing activity and increases opportunity.
- Many patients describe dissociation or a trance-like state during long episodes, with limited memory of how much damage was done.

DIFFERENTIAL & COMORBIDITY

- Exclude scabies, eczema, psoriasis, and pruritus from cholestasis, uremia, or thyroid disease before assigning a psychiatric diagnosis.
- Stimulant-induced formication and delusional parasitosis mimic the presentation, so obtain a urine drug screen when onset is abrupt.
- When picking serves to remove or correct a perceived appearance defect, diagnose body dysmorphic disorder instead of excoriation disorder.
- Comorbid trichotillomania occurs in roughly a third of patients, and depression, anxiety disorders, and OCD are all frequent.
- Distinguish from nonsuicidal self-injury, in which the intent is to produce pain or relieve emotional distress through deliberate injury.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No agent is FDA-approved; **N-acetylcysteine 1200-3000 mg/day** has the strongest randomized evidence in adults across 12 weeks.
- **SSRIs** such as fluoxetine 40-80 mg/day show mixed results for picking but treat comorbid depression, anxiety, and OCD effectively.
- **Lamotrigine** was no better than placebo overall, though patients with poor cognitive flexibility showed signal in secondary analyses.
- **Naltrexone 50 mg/day** is a reasonable trial when picking is described as pleasurable or strongly urge-driven rather than automatic.
- Treat secondary infection with appropriate topical or oral antibiotics and integrate wound care alongside the behavioral work.

PSYCHOTHERAPY

- **Habit reversal training** with awareness training and a competing response over 8-12 sessions is the best-supported intervention.
- Stimulus control removes tools and cues: cover mirrors, dim bathroom lighting, keep nails trimmed, and wear gloves or apply barriers.
- **Acceptance and commitment therapy** enhanced behavior therapy improves urge tolerance and reduces experiential avoidance of distress.
- Decoupling techniques and self-monitoring logs identify high-risk times, body sites, and emotional states for targeted intervention.
- Internet-delivered and guided self-help habit reversal programs show meaningful effects where in-person specialists are unavailable.

ADJUNCT & SUPPORTIVE

- Measure with the **Skin Picking Scale-Revised** or the Skin Picking Impact Scale at baseline and every 4-6 weeks thereafter.
- Coordinate with dermatology for wound care and scar management and to exclude a primary dermatologic driver of the itching.
- Substitute tactile input using textured objects, fidget tools, and short-nail grooming to satisfy the underlying sensory drive.
- Photographic documentation of lesion healing sustains motivation and provides objective outcome data that self-report misses.
- **TLC Foundation for BFRBs** support groups and family psychoeducation reduce the shame that drives concealment and delays care.

CLINICAL PEARLS

- Rule out scabies, stimulants, and cholestatic itch before calling it excoriation disorder.
- Barriers beat willpower: gloves, bandages, and covered mirrors change behavior fastest.
- Screen every skin picker for hair pulling; the two travel together.

References

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NOTE

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