

Cognitive behavioral therapy for excoriation (skin picking) disorder

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Abstract

In spite of excoriation (skin picking) disorder being first described in 1875, it has not yet been fully studied and understood. Furthermore over the years it has received multiple names (neurotic excoriation, psychogenic excoriation, pathological skin picking, compulsive skin picking) and only since late 2012 it has been included in diagnostic guidelines. Excoriation (skin picking) disorder can be a challenging condition for the non-experienced physician.

Cognitive behavioral therapy is the most common form of (and most effective in our experience) psychotherapy for the treatment of patients with excoriation (skin picking) disorder and other body-focused repetitive behaviors, such as trichotillomania. In this review article, we present the main elements of this type of psychotherapy in the treatment of these psychodermatology patients.

Key words: Excoriation disorder, Skin picking, Treatment, Cognitive behavioral therapy.

Introduction

Excoriation (skin picking) disorder was first described in 1875 by Erasmus Wilson, under the name of “neurotic excoriation”^[1], to describe difficult, if not impossible to control, excessive picking behavior in patients with neuroses^[2,3,4]. Studies have shown that the excoriation (skin picking) disorder has been called compulsive picking or psychogenic excoriation^[5,6].

Excoriation (skin picking) disorder is characterized by the need or urge to pick, scratch, pinch, touch, rub, scrub, squeeze, bite or dig the skin^[2,7]. Patients affected by this disorder feel compelled to perform those actions compulsively until typical lesions appear. The patient is aware of his/her self-destructive behavior but feels unable to give up this habit^[3,4,8], despite repeated attempts to decrease or cease it. Excoriation (skin picking) disorder can cause significant clinical distress or social, occupational and other impairments. The symptoms are not better explained by other mental or medical disorders^[9].

Patients use their fingernails or instruments such as tweezers or needles, causing tissue damage, resulting cellulitis, disfiguring scars, and a significant aesthetic and emotional damage^[10].

Three elements are invariably found in patients with excoriation disorder^[11]:

1. Recurrent skin picking, causing tissue damage;
2. Significant clinical distress as a result of skin picking; and,
3. The skin picking is not due to other medical or psychiatric illness or substance intake (body dysmorphic disorder, amphetamine use, skin diseases).

Psychotherapy as a first line treatment of excoriation (skin picking) disorder

Cognitive behavioral therapy (CBT) is the most common form of (and most effective in our experience) psychotherapy for the treatment of excoriation (skin picking) disorder and other body-focused repetitive behaviors, such as trichotillomania^[12,13,14].

CBT seeks to modify several backgrounds and consequences of maintaining skin picking behavior; moreover, the consistent application of cognitive-behavioral techniques will achieve relatively permanent changes in brain function.

CBT in automatic skin picking

Stimuli control: In our experience, stimuli control technique is based on teaching patients to use techniques in situations that otherwise would trigger pick behavior.

Before teaching the technique, the physician must assess the patient's severity of the picking behavior and must ask the patient to daily monitor his/her own behavior. When one of these picking behaviors occur, the patient should take note of where (context) and when (time, activities at that moment) it occurred, what he/she was thinking and feeling before and after picking and how emotions and thoughts changed that behavior^[13].

After performing the above evaluation and studying the patient's self-report, the physician can design interventions to reduce the repetitive behavior. The overall objective of the stimuli control technique is to make the picking behavior much more difficult to the patient and to provide ways to avoid the positive reinforcement that typically produces the repetitive

behavior. Table 1 shows common interventions to control stimuli, for various situations that could cause picking behaviors^[13,14].

Table 1: Interventions to control stimuli

Situation	Possible intervention
Watching television	Keep both hands busy, opening and closing the fists, or holding objects such as rubber balls.
Driving (in adolescents)	Keep both hands on the hand wheel.
Reading a book	Hold another object (like a rubber ball) with the free hand or hold the book with both hands
Bedtime	Go to bed only when you are tired; if you do not fall asleep within 10 minutes, get up and come back later.
Using sharp objects and tools	Remove all kinds of sharp or pointed objects (needles, pins, brooches) from portfolios, backpacks and the whole house.

Habit reversal training: Habit reversal training, developed by psychologists Azrin and Nunn^[15], is another key component of CBT in the treatment of people with excoriation (skin picking) disorder.

Habit reversal training has three steps: sensitization and awareness, competing response training and social support^[13,14]. Sensitization and awareness includes describing the skin picking, the feelings and behaviors that precede it, and the recognition of the repetitive behavior itself^[16]. Often, skin picking occurs automatically, without the patient noticing. For the patient to recognize his/her behavior, he/she is asked to make detailed notes of the picking behavior, including feelings, warning signals or behaviors that occur before the picking episode. These feelings may be skin tingling, tension or and overwhelmed feeling. On the other hand, the warning signals include rubbing the skin or taking the hand to the place where picking usually occurs, among other signals. The physician shall work with the patient in order to identify two or three warning signals.

In competing response training, the physician teaches the patient to perform a behavior to prevent skin picking. This preventing behavior should be performed for at least one minute, as soon as the patient realizes that skin picking behavior has started or that a warning signal has appeared^[17]. A competing response usually taught is to cross arms and gently squeeze the fists. In our experience, any behavior can be used as a competing response, when the following conditions are met:

1. While the chosen competing response is being held, skin picking is impossible;
2. The chosen competing response can be used in any situation and/or setting;
3. The chosen competing response cannot be noticed by other people; and,
4. The chosen competing response has the patient's acceptance.

The patient must practice the competing response during consultation with the physician. The physician should teach the patient that, as mentioned in the preceding paragraphs, the competing response should be used for at least one minute; and if after the first minute the urge to pick the skin comes back, the competing response should be repeated again.

During consultation, symbolic rehearsal would be used by the physician in order to help the patient to practice imaginary and different situations that could trigger skin picking and that could be faced with the competing response.

Social support is based on the choice of an individual close to the patient (friend, relative, partner), who will be responsible for noting the patient's picking behavior, helping the patient to become more aware of it and encouraging him/her to practice the competing response. It is important to stress that an affective social network is essential in order to ensure that the patient is becoming aware of the skin picking behavior.

Finally, after the therapeutic process is finished, the patient is deliberately exposed to different situations or settings that had previously been avoided, in order to strengthen the achievements and internalize the sought changes.

CBT in conscious skin picking

Emotion regulation: In addition to the stimuli control and habit reversal training, there are other direct and indirect strategies to help patients reduce skin picking and cope with difficulties in regulating emotions^[14].

The direct change strategies include progressive muscle relaxation training and cognitive restructuring^[14].

Progressive muscle relaxation can be used to reduce tension and stress (which can trigger skin picking). The physician must teach the patient to contract and relax various muscle groups, so that he/she can respond when tense moments occur (through muscle contraction recognition)^[18].

Cognitive restructuring is the process of assessing, challenge and change maladaptive beliefs that usually perpetuate a problem. In the treatment of these patients, it is important to identify and, subsequently, modify cognitive precursors of skin picking because many people pick their skin in order to reduce negative or irrational emotions or feelings. The physician should work with the patient to recognize negative or irrational thoughts that precede skin picking, to modify them through cognitive restructuring^[19].

The indirect change strategies include those based on acceptance (derived from the acceptance and commitment therapy^[20]). Physicians must not confuse acceptance with resignation. The acceptance-based technique used in patients with trichotillomania and excoriation (skin picking) disorder involves the patient recognizing emergencies, cognitions and other emotional experiences for what they are and let them pass without performing repetitive behaviors as a result^[14].

Psychoeducation

Informing patients about the details of the repetitive behavior and that they are not the only ones with the disorder is beneficial for them. Patients are surprised to learn that the disorder is common in the general population and that many other people also suffer from the same condition.

The physician must also educate the patient's partner, carers, and family about the nature, course, prognosis and treatment of the disorder and use that opportunity to detect problems within the dynamics of the family, generated by the presence of the repetitive behavior. The physician, also, should teach the family the need to strengthen behaviors that prevent skin picking, without using aggression or punitive damages styles.

Finally, physicians can also establish a rewards system to reinforce the use of treatment techniques by the patient^[18].

Conclusions

Cognitive behavioral therapy (CBT) is the first-line treatment for patients with excoriation (skin picking) disorder and other body-focused repetitive behaviors, such as trichotillomania.

In excoriation (skin picking) disorder, the fundamental elements of CBT can be divided into two groups^[14]:

- A group of techniques designed to address the factors that exacerbate and maintain automatic skin picking (stimuli control and habit reversal training); and,
- Another group directed to conscious picking behaviors, in which the patient is aware of the behavior (progressive muscle relaxation training, cognitive restructuring and acceptance-based and commitment therapy).

Although these techniques are described separately, CBT typically involves all of them; however, some techniques may be more emphasized according to each patient's characteristics.

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