

Acceptance-Enhanced Behavior Therapy for Excoriation (Skin-Picking) Disorder in Adults: A Clinical Case Series

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Excoriation disorder (ExD) involves habitual skin picking that causes significant tissue damage and psychosocial impairment. ExD is largely understudied, and efficacious treatments have yet to be established. Preliminary evidence suggests that habit reversal is a promising intervention for ExD and that acceptance and commitment therapy (ACT) techniques may further enhance the efficacy of habit reversal. This report details treatment of ExD in four adults using a combination of habit reversal and ACT, termed acceptance-enhanced behavior therapy (AEBT). Three of four patients experienced a clear decrease in ExD symptoms from pretreatment to posttreatment. Clinical considerations and directions for future research are discussed.

Excoriation disorder (ExD) is marked by (a) recurrent self-inflicted skin damage (via picking, scratching, or other means), (b) failed attempts to stop the behavior, and (c) substantial resulting distress and/or impairment (American Psychiatric Association, 2013). In a nonreferred population-based survey, as many as 17% of adults reported having engaged in repetitive skin picking resulting in physical damage at some point in their lives (Keuthen, Koran, Aboujaoude, Large, & Serpe, 2010). Of those, 1.4% reported significant distress and impairment as a result of their picking, consistent with a diagnosis of ExD (Keuthen et al., 2010). Negative sequelae of ExD include skin damage from picking, psychological distress, and psychosocial impairment (e.g., avoidance of social situations, missing work; Tucker, Woods, Flessner, Franklin, & Franklin, 2011). Onset is typically in adolescence, and ExD follows a chronic course (Flessner & Woods, 2006; Wilhelm et al., 1999). Females are disproportionately affected by a ratio of 8:1–9:1 (Arnold, Auchenbach, & McElroy, 2001; Flessner & Woods, 2006; Tucker et al., 2011). Although ExD is a distinct psychiatric condition and may occur in the absence of other psychopathology, patients with ExD also exhibit high rates of anxiety disorders (including obsessive-compulsive disorder), mood disorders, eating disorders, and substance use disorders (Arnold et al., 1998; Odlaug & Grant, 2008). Additionally, some studies have found high rates of

personality disorders, especially obsessive-compulsive and borderline personality disorders among treatment-seeking individuals with ExD (Lochner, Simeon, Niehaus, & Stein, 2002; Wilhelm et al., 1999). Co-occurring psychiatric disorders can exacerbate the severity of skin picking, which may occur in response to the negative affect associated with these conditions (Wilhelm et al., 1999).

Despite the long-standing discussion of ExD in the medical literature (e.g., Wilson, 1875), relatively little is known about its treatment. Pharmacological treatment with fluoxetine and other selective serotonin reuptake inhibitors may be somewhat efficacious; however, findings are mixed, and evidence is somewhat limited by small sample sizes and patient dropout (Arbabi et al., 2008; Bloch, Elliott, Thompson, & Koran, 2001). Positive outcomes also have been reported for several different modalities of behavioral or cognitive-behavioral therapy. Of these interventions, habit reversal training (HRT) is the best studied. HRT involves teaching patients to detect early signs of picking and engage in a prescribed behavior (i.e., a “competing response”) that is physically incompatible with the act of skin picking. In a randomized trial, a brief HRT intervention outperformed a wait-list control (Teng, Woods, & Twohig, 2006). This is consistent with preliminary evidence showing significant decreases in skin picking with HRT alone (Twohig, & Woods, 2001) or embedded as a component of a broader course of cognitive-behavior therapy (Deckersbach, Wilhelm, Keuthen, Baer, & Jenike, 2002; Schuck, Keijsers, & Rinck, 2011). Despite these promising results, patients treated with HRT rarely have shown full symptom remission, suggesting that additional research could be helpful in enhancing the efficacy of behavioral interventions for ExD.

Keywords: excoriation disorder; skin picking; habit reversal training; acceptance and commitment therapy

Research on phenomenology of ExD suggests possible routes to treatment refinement/development. A large body of evidence shows that body-focused repetitive behaviors (e.g., skin picking, hair pulling, and oral habits) can be associated with various behavioral functions, which has led researchers to identify different behavioral subtypes. The two most common of these are “automatic” and “focused.” Automatic picking is associated with a lack of awareness of the behavior as it occurs (e.g., a patient who, while watching TV, finds that his or her hand has “wandered” to his or her leg and begun to pick), whereas focused skin picking is generally preceded by negative affect or a salient urge to pick, and occurs within the individual’s awareness (Walther, Flessner, Conelea, & Woods, 2009; Woods & Miltenberger, 1995). Higher levels of focused picking correlate with overall skin-picking severity, anxiety, depression, and experiential avoidance, whereas automatic picking is unrelated to these other variables (Walther et al., 2009). Given traditional HRT’s exclusive focus on disrupting the overt behavior of skin picking, it appears well suited to address automatic picking. However, HRT appears to do little to address the aversive internal states that drive focused picking.

As a result, researchers have suggested that additional components be added to aid clients in coping with these aversive feelings. Acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999) has shown promise as an adjunct to HRT in the treatment of both skin picking and trichotillomania (hair-pulling disorder; Crosby, Dehlin, Mitchell, & Twohig, 2012; Flessner, Busch, Heideman, & Woods, 2008). Put simply, ACT aims to break patterns of experiential avoidance (in which individuals think and behave with the primary goal of reducing immediate psychological distress), while increasing the frequency of behaviors that align with the individual’s values and life goals. This is accomplished via a variety of experiential exercises that aim to weaken the control of aversive internal stimuli (i.e., promote “cognitive defusion” from them) and place such stimuli in a new verbal context, in which they no longer necessarily control the individual’s behavior (see Hayes et al., 1999, for a book-length explanation).

There are several reasons why ACT may be a particularly useful addition to HRT (Crosby et al., 2012). First, it addresses the negative reinforcement associated with reduction of urges and negative affect that maintain focused picking. This is accomplished by reframing the urge in a new functional context, as a stimulus that may be experienced but not “followed,” via the use of metaphor, experiential exercises, and cognitive defusion techniques; that is, ACT aims to break the discriminative control of urges and negative affect over overt behavior. Second, ACT prompts clients to engage in out-of-session “behavioral commitment” exercises, in which they engage in values-

consistent behavior. In the case of HRT, using the competing response could be framed as a values-consistent alternative to picking. Third, by putting the patient’s picking in a larger context of his or her values and life aspirations, ACT may increase the patient’s motivation to use HRT techniques both during acute treatment and following treatment termination, thereby increasing both acute treatment effects and long-term treatment durability.

Based on these considerations, researchers have begun to investigate the effects of combining these two interventions, in an approach termed “acceptance-enhanced behavior therapy” (AEBT; Woods & Twohig, 2008). Evidence suggests that AEBT is efficacious in the treatment of trichotillomania (Woods, Wetterneck, & Flessner, 2006), but little is known about its effects on skin picking associated with ExD. In the only published study to date of AEBT for skin picking, Flessner and colleagues (2008) found that a combined HRT+ACT intervention, in which HRT was administered early in treatment and ACT skills were introduced subsequently, was successful in decreasing the frequency of skin picking in two patients.

In this report, we expand on Flessner and colleagues’ (2008) study by describing the assessment and AEBT-based treatment of four patients who presented consecutively to a specialty clinic for the treatment of ExD.

Method

Patients contacted our clinic for services after being referred through community practitioners or locating the clinic via the directory of an online patient organization (the Trichotillomania Learning Center). We used no formal inclusion/exclusion criteria for receiving treatment through the clinic, and the individuals described in this report presented consecutively to the clinic. Services were provided on a fee-for-service basis according to a sliding-scale fee schedule. Therapy was delivered in weekly sessions in an outpatient specialty clinic located in a medium-sized Midwestern city. The therapist was a female, doctoral-level psychologist with extensive training in ACT and 3 years of prior experience treating skin-picking disorder and trichotillomania. She received supervision weekly in a group setting from an expert in the treatment of skin picking and hair pulling. The AEBT manual (Woods & Twohig, 2008) for trichotillomania was used as a framework for treatment, with content-related adaptations made to focus on skin picking.

Acceptance-Enhanced Behavior Therapy

The AEBT protocol outlines ten 60-minute therapy sessions (Woods & Twohig, 2008). In Session 1, the therapist explains the treatment, discusses psychoeducational material about skin picking with the client, and conducts a functional assessment interview with the aim of identifying factors that trigger or maintain the picking

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