# A review on Skin Picking Disorder (Excoriation Disorder): Pathogenesis and Therapeutic Approaches

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**Abstract**

Skin Picking Disorder (SPD), also known as Excoriation Disorder, is a chronic psychiatric condition characterized by recurrent compulsive picking of the skin, leading to tissue damage, scarring, and significant psychosocial impairment. Classified under the Obsessive–Compulsive and Related Disorders in the DSM-5, SPD affects approximately 1.4–5.4% of the general population, with a higher prevalence in females. Its pathogenesis is multifactorial, involving genetic predisposition, neurobiological abnormalities, and environmental triggers. Dysregulation of cortico-striato-thalamo-cortical (CSTC) circuits, serotonergic and dopaminergic imbalances, and altered reward processing are implicated, alongside heightened stress reactivity and maladaptive emotion regulation. Comorbid psychiatric conditions such as anxiety, depression, and body dysmorphic disorder are common, complicating diagnosis and management.

Therapeutic approaches are evolving, with behavioural interventions, particularly Habit Reversal Training (HRT) and Cognitive Behavioural Therapy (CBT), showing strong efficacy. Pharmacological options include selective serotonin reuptake inhibitors (SSRIs), N-acetylcysteine (NAC), and glutamatergic modulators, although responses vary. Novel approaches, such as acceptance and commitment therapy (ACT), mindfulness-based interventions, and neuromodulation techniques, are being explored to address treatment-resistant cases. Early identification and a multidisciplinary approach integrating dermatological and psychiatric care are crucial for optimizing outcomes.

Despite growing recognition, SPD remains underdiagnosed and undertreated due to stigma and limited awareness. Further research is required to elucidate precise neurobiological mechanisms, refine diagnostic tools, and develop targeted, personalized treatments. This review synthesizes current evidence on SPD pathogenesis and therapeutic strategies, highlighting emerging interventions and future directions for improved management of this often-neglected disorder.

## 1. Introduction

- **Definition and classification (DSM-5): -** Neurotic excoriation and dermatillomania are distinct synonyms for skin picking (excoriation) condition, which is marked by an inability to resist the urge to pick at one's own skin. More than a century ago, Eramus Wilson was the first to characterize skin picking condition. Most references to skin picking disorder are restricted to small case series (n < 60) that used various diagnostic criteria as they were conducted prior to the DSM nosological system including skin picking disorder, despite the fact that it was recognized as a distinct psychiatric disorder classified in the Diagnostic and Statistical Manual Version 5 (DSM-5) under the category of "obsessive compulsive and related disorders"(1). Often referred to as excoriation disorder or pathological skin picking (PSP), skin-picking disorder (SPD) is a common psychocutaneous condition marked by a persistent urge to pick at the skin compulsively and repeated attempts to avoid the picking that fail, causing visible skin lesions(2).

  Hair pulling condition, also known as trichotillomania, and other repeated behaviours that are focused on the body, including compulsive nail and cheek biting, are frequently regarded to be strongly connected to SPD. Picking that is purely caused by a medical condition (like dermatological issues), another mental illness (like body dysmorphic disorder), or the effects of drugs (like stimulants) is prohibited by excluding criteria(3).
  Patients with SPD have difficulty controlling their maladaptive behaviour and frequently make numerous unsuccessful efforts to stop. The weight of physical agony, shame, and the urge to conceal their wounds and scars also causes them to experience mental misery. The protective skin barrier is weakened by this behaviour, leaving it vulnerable to infections and chemical and mechanical assaults. Life-threatening infections from compulsive skin-picking can spread to other structures and cause pyogenic myositis, septicaemia, and/or osteomyelitis(4).

  Attention-deficit/hyperactivity disorder (ADHD) and posttraumatic stress disorder (PTSD) are two comorbid disorders that SPD patients may also exhibit; the use of amphetamine-based stimulant drugs may be a contributing factor. A recent study evaluated the mental comorbidities of 262 SPD patients, finding that 8% had ADHD, 21.5% had major depressive disorder, 21.8% had generalized anxiety disorder (GAD), and 24.4% had trichotillomania(1). 52 individuals in a different study that evaluated comorbidities and risk factors for SPD throughout life self-reported having high levels of obsessive compulsive disorder (OCD), sadness, and anxiety(5).

  With estimated incidence rates for ED ranging from 1.4% to 5.4%, skin-picking is a rather prevalent behaviour. Although it can happen at any age, ED usually first manifests in

adolescents, sometimes around puberty. According to the bulk of research, ED often manifests between the ages of 30 and 45, and women make up the majority of those seeking therapy(6).

- **Epidemiology and demographics**: - Three-quarters of those with SPD are female, and the lifetime incidence in adults is 1.4%. Nevertheless, new research indicates that this issue may worsen and that it is more common than already believed. The onset is usually associated with acne and usually happens throughout adolescence. The aforementioned diagnostic criteria for SPD are notably met by 1.2% of the general population. Significant depression (8–28%), drug addiction (14–36%), anxiety disorders (up to 48%), and a worse quality of life are all linked to the severity of SPD(7)**.**

  Several minor studies have examined the prevalence of skin picking condition, but no countrywide epidemiological research have been carried out as of yet. The vast bulk of the research has been carried out in academic environments. Among college students (n = 4335), 5.7% self-reported having a clinical form of skin picking disorder, which is defined as occurring at least five times per day, causing physical damage such as skin lesions, and causing significant distress and/or functional impairment, according to a recent electronic study that looked at the prevalence of skin picking in the previous month(8)**.**
  2.1% of 48 females with trichotillomania in an early research by Christenson had borderline personality disorder. Among 43 people with trichotillomania, Swedo and Leonard found that 18% had borderline personality disorder. Trichotillomania was found in 14% of the women in a small study (n=22) by Schlosser and colleagues. 26% of the 31 females with skin picking (who were evaluated before the DSM-5 criteria) in the study matched the conditions for borderline personality disorder. Lastly, according to Lochner and colleagues, 13.3% of 68 persons with trichotillomania and 33.3% of 21 adults with skin picking condition had borderline personality disorder(9).

- **Impact on quality of life: -** In addition to having a worse quality of life (QoL), SPD has been linked to high rates of co-occurring anxiety, mood, drug use, and other OCRDs. It is unknown how SPS affects QoL measures with multivariable adjustment to clinical and sociodemographic factors (such as co-occurring mental illnesses). Further study in community or nonclinical samples is necessary, nevertheless, as the connections between SPD and co-occurring mental illnesses and QoL are mostly drawn from clinical samples. The relationship between SPD and suicidality has also not been fully clarified, however in more severe clinical circumstances, SPD can lead to serious and even fatal medical consequences (such as

septicemia). Furthermore, skin picking and exposure to sexual abuse in childhood have been shown to be significantly linked in a recent community research(10). Acne, psoriasis, or eczema are common dermatological conditions that first manifest as PSP. Significant tissue damage and scarring may arise from the picking behaviour, which occasionally may even call for surgery and, in extreme circumstances, may even be fatal. People with PSP seldom seek out dermatological or psychological care because they are embarrassed or think their illness cannot be cured. Clinical significance may arise from an awareness of the traits and quality of life of those who engage in this behaviour. When choosing to give proper mental health treatment and therapies, clinicians must understand the emotional and psychological consequences(11).

**2. Clinical Presentation**

- **Common symptoms and behaviours: -** The DSM-5 introduced a new chapter titled Obsessive-Compulsive and Related Disorders (OCRDs), which includes obsessive-compulsive disorder (OCD) as well as body dysmorphic disorder (BDD), hoarding disorder (HD), trichotillomania/hair pulling disorder (HPD), and excoriation/skin picking disorder (SPD). All illnesses are characterized by repeated and compulsive behaviours, and those who suffer from them feel distressed or impaired, have little to no control over their symptoms, and avoid situations or people because of them. The research on body dysmorphic disorder, hoarding, hair pulling, and skin picking in adolescence is quite limited(12). The repetitive compulsive routines in OCD and the repetitive motor signs of skin picking disorder are quite comparable(13). Recurrent picking of the skin (e.g., to get rid of acne) is a hallmark of SP, resulting in skin lesions and repeated attempts to reduce or stop the behaviour. Onychophagia, also known as nail biting (NB), is presently a recognized non-official diagnostic condition. Biting or chewing fingernails and sometimes toenails repeatedly is known as NB. In addition to a potential bacterial infection, the behaviour can cause severe emotional discomfort because of feelings of guilt, humiliation, and deformity(14).

**3. Pathogenesis and Etiology**

**3.1 Biological Factors**

- **Genetic predisposition: -** Monozygotic twins had a greater concordance rate for OCD than dizygotic twins, according to the first research to suggest a genetic component to OCD. There is growing evidence that some risk for these linked illnesses is also based on hereditary reasons,

even though skin picking condition has received less attention in research. Heritability estimates for OCD and similar disorders are as high as 50%, according to these twin studies and later family investigations. Concordance rates for skin-picking disease have been shown to be greater in monozygotic twin pairs than in dizygotic ones. The heritability estimate for persistent skin picking disease in female monozygotic and dizygotic twin pairs was 40% in a population-based investigation evaluating concordance rates. With an estimate of 47%, a follow-up investigation revealed a somewhat greater heritability(15).

- **Neurobiological mechanisms: -** The epidermis and the nervous system, of which the brain is the main organ, originate at the same time as the embryo. Since they are both ectodermal in origin, they interact significantly (16)**.** The neural structures or processes that contribute to the genesis of SPD. In contrast to controls, recent structural imaging of SPD revealed less fractal anisotropy in bilaterally distributed pathways, including white matter around the anterior cingulate cortices. Numerous studies have linked OCD to a combination of a lack of top-down input from cortical areas (particularly the medial and lateral prefrontal regions) engaged in different cognitive processes and dysregulation of the striatum, which is involved in habit formation(17).

- **Brain imaging findings (frontal-striatal circuits): -** Frontal striatal circuit impairment is linked to SPD in independent cognition and imaging investigations. As assessed by stop-signal tasks, SPD participants exhibit more motor impulsivity than both trichotillomania's and healthy controls from a cognitive standpoint. Motor control circuits are also implicated in the pathogenesis of SPD by neuroimaging investigations. White matter anomalies around the bilateral anterior cingulate cortex, which is engaged during failed response inhibition, were linked to SPD in a diffusion tensor imaging study. Additionally, the anterior cingulate cortices, dorsal striatum, and right-medial frontal regions—structures similarly implicated in the creation and repression of movement—were shown to be significantly hypo-activated in a functional neuroimaging research that compared people with SPD to healthy controls. Lastly, a structural research discovered that the inferior frontal gyrus, orbitofrontal cortex, and nucleus accumbens—frontal regions linked to impulse control—had changed cortical thickness and brain volume in SPD individuals. Participants with trichotillomania also had the Para hippocampal gyrus involved, but those with SPD did not. This suggests that the repeated picking behaviour that defines SPD may be influenced by abnormalities in frontostriatal circuits that exert top-down inhibitory control (18).

### 3.2 Psychological and Environmental Triggers

- **Childhood trauma or stress: -** Major depressive disorder and OCD are the most common co-occurring disorders with SP disorder. According to reports, women experience it more frequently(19)**.** In addition to having a detrimental impact on quality of life, SP is linked to psychological discomfort, including worry, anxiety, tension, depression, and trouble managing emotions. Picking behaviour can serve as both positive and negative reinforcement for these disorders.The condition results in social humiliation and shame, which leads social disengagement and avoidance behaviour(20).
- **Emotion regulation deficits: -** Emotion control tactics might include repetitive behaviors like skin-picking or hair-pulling. However, these tactics are seen to be maladaptive because, although offering short-term respite, they eventually make psychopathological symptoms worse (e.g., despair, anxiety, guilt, negative self-image, poor self-esteem). These tactics are typically used when stress becomes too much for a person to handle, as occurs with trauma exposure to handle (21).
- **Behavioural reinforcement and habit formation: -** Following a skin ailment (such as acne or eczema), skin picking may start and develop into a more ritualistic and repetitive behavior as a coping mechanism for mental states like anxiety. Stressful situations, frustration, anxiety, depression, tension, and boredom are some of the possible triggers that have also been linked to skin-picking episodes. Effective management is necessary since dermatitis may have a number of negative effects, such as severe tissue damage, scarring, decreased psychosocial functioning, and an increased risk of suicide. It is also linked to other co-morbidities, most often anxiety disorders and depression(22).

### 3.3 Sociocultural Factors

- **Body image issues: -** Body image may be significant in SP for several reasons: First of all, SP is primarily concerned with the individual's body, and it stands to reason that how one views one's body also affects how one treats it. Second, SP damages the skin and frequently leaves lasting scars, which probably influences how a person views their body. Third, the psychosocial dysfunction associated with SP is typically motivated by feelings of guilt and anxiety about how other people may view and assess one's own body(23).
- **Others:** - Eczema and acne are examples of dermatological diseases that can cause ED, as can stress, anger, and anxiety, as well as sedentary activities like reading, watching television, and

being bored or tired. In order to "detect a defect" on the skin's surface, self-harm is frequently preceded by a visual examination or touch. Following the self-harm phase, there is a brief time of relief and inner fulfilment once all the scabs are gone. But later, pain and skin dissatisfaction return, coupled with a strong desire to change the rash's already-existing features. Numerous psychological repercussions have also been observed, such as social shame, avoiding activities or circumstances where skin lesions may be seen, and a decline in productivity in many settings(6).

**4. Diagnosis and Assessment**

- **Diagnostic tools (e.g., SCID, MINI, structured interviews):-** A computer-assisted variation of the mini-SCAN, the DSI is a Dutch semi-structured interview. The tiny SCAN is a condensed form of the SCAN, and both devices were determined to be reliable. Adapted to DSM-5 criteria and incorporating more DSM-disorders, the DSI builds upon the mini-SCAN and was developed with consultation from clinical specialists. The DSM-5's DSI has not yet been verified. Because the DSI is computer-assisted (e.g., automated logic calculations and branching, suitable prompts automatically supplied, depending on prior responses) and incorporates a self-scoring method to establish the classifications, it is easier to use than the SCID or the (mini-)SCAN. Moreover, the DSI has fewer elements, which reduces the time needed for administration(24).

  Comparable to the Trichotillomania Diagnostic Inventory Revised (TDI-R), the Skin Picking Diagnostic Inventory (SPDI) is a skin-picking assessment conducted by a physician. Modeled after DSM-IV criteria for Trichotillomania (TTM), the diagnostic criteria for SPD and persistent skin picking (CSP), a diagnosis that is mostly equivalent to DSM-5 SPD. Responses to six items measuring these diagnostic criteria are rated on a 3-point scale in the SPDI. SPD/CSP was evaluated using the SPDI(25).
- **Self-report scales (e.g., Skin Picking Scale-Revised):-** Although mental health comorbidity with skin problems has gained attention, screening and evaluation procedures are not universally agreed upon. Patients can self-report on their sickness or condition using evaluation tools called Patient Reported Outcome Measures (PROMs). Patients can report on symptoms including emotions, thinking processes, and poor mood that may not be readily visible, which makes them essential for informing mental health assessments. Parent and Subordinate Similar goals are achieved by Reported Outcome Measures, which are provided by the patient's family. The structure of the questionnaire enables them to be self-completed in writing or online.

According to a recent study conducted in neurology clinics, 98% of parents thought the computerized screening procedure was satisfactory(26).

- **Role of dermatologists vs. psychiatrists:-** The dermatologist can start building a relationship with the patient by treating their skin and employing technical techniques like wound healing treatment, which might inspire them to discuss additional personal problems. Emollients and simple topical therapies can occasionally help patients become less reluctant to discuss subjects other than their skin problem. For the patient who would rather not discuss self-harm and suppressed emotions, focusing first on the therapy of the skin lesions may be less frightening or scary. One tool for encouraging an ambivalent patient to stick with psychosomatic–psychiatric treatment is a trustworthy dermatological connection. By making references to the emotional struggles and skin conditions of other patients, indirect speech might reveal information about the patient's knowledge or willingness to discuss underlying issues. A psycho-dermatological approach's efficacy may also be shown by this(27).

  Since excoriation disorder is now included individually in the DSM-5 as an obsessive compulsive disorder and related disorders, psychiatrists can anticipate seeing more patients with this problem referred to their practice as dermatologists and family doctors become more aware of it. Pharmacotherapy and psychotherapy are the forms of treatment that the psychiatrist will provide to these patients after evaluating them for the illness and any co-morbid disorders(28).

**5. Treatment Approaches**

**5.1 Psychotherapeutic Interventions**

- **Cognitive Behavioural Therapy (CBT):-** According to the American Psychological Association, cognitive behaviour therapy (CBT) is a therapeutic approach aimed at identifying troublesome thinking dysfunctions and creating plans to modify thought and behaviour patterns in response to stresses in the future. It is predicated on the fundamental idea that difficult circumstances frequently provoke harmful thought processes and undesirable behavioural patterns. CBT is recommended to improve self-awareness and change negative ideas and emotions over the course of five to twenty brief treatment sessions. This will make future reactions to difficult situations more successful. CBT has proven successful for an assortment of mental health conditions, such as eating disorders, anxiety, depression, and attention deficit and hyperactivity disorders (ADHD). Menopausal symptoms, postpartum depression, sleeplessness, bulimia nervosa, and other disorders that disproportionately impact women can

all benefit from its use in conjunction with medicine for chronic pain, diabetes, and other illnesses. Individuals may suffer from severe emotional anguish when they come with skin lesions in sensitive and conspicuous body parts. It follows that it is crucial to be aware of the incidence of psychological complications in disorders of the skin(29).

- **Habit Reversal Training (HRT):-** In response to the treatment gap—caused by things like the embarrassment of those who are impacted or the scarcity of qualified therapists—HRT-based self-help strategies have emerged more recently(30)**.** Up until now, HRT has mostly been studied in relation to other habit-based problems. There is currently a dearth of published information about how hormone replacement therapy (HRT) affects OCD symptoms. Along with SSRIs and other behavioral therapies, hormone replacement therapy is one of the few treatments for trichotillomania that is believed to be successful. Along with a few other therapies that are believed to be beneficial, such SSRIs, glutamatergic drugs, and cognitive behavioural therapy, research is beginning to examine the efficacy of hormone replacement therapy (HRT) in treating excoriation disorder. Hormone replacement therapy (HRT) has been employed in this research in a number of modified forms. For instance, a case series of individuals with Excoriation Disorder showed some benefit with Acceptance Enhanced Behavior Therapy (AEBT), which combines Acceptance and Commitment Therapy (ACT) with hormone replacement therapy (HRT)(31).
- **Stimulus control:-** Sometimes, HRT is used with stimulus control. When skin picking occurs often in a particular setting, the surroundings and certain items may act as triggers. Thus, staying away from these places and items might lessen skin picking. Since stimulus control primarily deals with external picking and pulling triggers, it's critical to distinguish between internal and external triggers while using it. Lowering duration spent in provoking surroundings, wearing gloves, and getting rid of equipment are a few examples of stimulus management techniques(32)**.**
- **Acceptance and Commitment Therapy (ACT):-** Dedication and acceptance Instead than trying to ignore, control, or run away from thoughts, feelings, bodily sensations, picking desires, or boredom, treatment focuses on practice and development of a receptive attitude toward these things. Additionally, the therapy encourages a "commitment" to make decisions that align with the patient's personal ideals and aspirations, which is advantageous for skin plucking(33)**.**

### 5.2 Pharmacological Treatments

6 **SSRIs (e.g., fluoxetine, Sertraline):-** These block serotonin's absorption into presynaptic cells, hence raising its levels in the synaptic cleft. Because of their favourable side effect profile and improved tolerance, they are recommended as first-line antidepressants.

**fluoxetine** :- Body dysmorphic disorder, pathologic skin plucking, and neurotic excoriations can all benefit from it. Eight of the fifteen participants in an open-label, double-blind research to determine the effectiveness of fluoxetine in treating pathological skin picking reacted within six weeks. Four fluoxetine-treated individuals continued to improve after randomization, whereas the other four placebo-treated patients saw a return to their pre-treatment symptom levels(34).

**Sertraline:-** In cases with skin picking disorder, persistent pruritus, neurotic excoriations, and TTM, sertraline is recommended. The suggested beginning dose is 50 mg once daily, with a gradual monthly increase of 50 mg for partial responders. The pills come in 25 mg, 50 mg, and 100 mg dosages. Sertraline showed promise in significantly decreasing skin picking behaviours in an open label trial, with a noteworthy 68% response rate(35).

7 **N-acetylcysteine (NAC) :-** Acetylcysteine's glutamate modulatory and antioxidant properties are responsible for the symptoms of skin picking disorder. In one short case series, N acetylcysteine was used to treat skin picking in Prader-Willi syndrome patients. 66 individuals with skin picking condition participated in a double blind, randomized, placebo-controlled study. Acetylcysteine (1200–3000 mg/day orally) was observed to lessen the impulse or craving to pick the skin when compared to a placebo. Because of the limited sample size and the very brief 12-week follow-up period, the authors concluded that there was no statistically meaningful improvement in the patients' quality of life. Three subacute prurigo patients who took 1200 mg of n-acetylcysteine orally showed varying degrees of improvement in skin appearance and skin picking. However, more research on skin-picking disorder patients is required before a definitive assessment of its effectiveness can be made(36).

8 **Glutamatergic agents (e.g., lamotrigine):-** Lamotrigine is mostly used to treat seizures, however it has also been shown to be effective in treating skin picking. There is evidence that dosages ranging from 12.5 mg to 300 mg per day should be used. The drug works by stabilizing membranes, limiting glutamate release, and lowering neuronal excitability, albeit the precise mechanism of action is unknown (37).

9 **Atypical antipsychotics (in resistant cases):-** Patients with signs of delusions may benefit from atypical antipsychotic(38). Comparing atypical antipsychotics to first-generation

antipsychotics, the former decrease dopamine neurotransmission by partial agonism at D2 receptors with faster dissociation. Moreover, they inhibit the serotonin receptor, 5-HT2A (39).

**5.3 Integrative and Emerging Therapies**

- **Mobile apps and digital CBT :-** With further development, these digital tools might supplement conventional behavioural therapy and offer a more comprehensive approach to treating children's skin plucking (40). New digital solutions that can identify BFRB episodes may be made possible by recent developments in wearable technology and sensing systems. This could lead to opportunities for prompt interventions to stop ongoing episodes or even anticipate them before they begin(41). Other long-term diseases have been successfully managed with the use of digital technology interventions, such as those utilizing the internet and smartphone applications (apps). People with type 2 diabetes and cancer, for instance, view them as a practical and helpful supplement to normal treatment that educates, empowers, and enables people to take charge of their health and way of life. There aren't many digital health treatments in the field of dermatology; some have been created primarily for primary prevention of skin cancer. It's unclear what works or what distribution techniques are appropriate to individuals with dermatological disorders, but digital technology may offer a platform for providing psychological assistance(42).

- **Transcranial magnetic stimulation (TMS):-** Transcranial magnetic stimulation (TMS) is one technique to stimulate or inhibit specific brain activity, causing neuroplastic alterations in cortical neurocircuitry. Extracranial magnetic fields are used in TMS, a non-invasive technique, to generate cortical electrical activity, which in turn generates a stimulatory impulse to cortical neurons. Induction, suppression, or neuronal activity can be achieved based on TMS settings. The motor and premotor cortex have long been considered obvious targets for TMS in TS, but more recently, the supplementary motor area (SMA) has emerged as a viable alternative(43). Alongside trichotillomania, skin picking condition is also frequently observed. Patients with trichotillomania have been shown to have a number of neurobiological abnormalities in their brains. According to Chamberlain et al., trichotillomania patients have thicker cortical tissue in the area of the right inferior frontal gyrus, whereas impulsive-compulsive illnesses such as OCD, ADHD, and gambling disorders have thinner cortical tissue. Patients with body-focused repetitive disorders such as trichotillomania and skin plucking disorder exhibit hyperactivation of the bilateral inferior frontal gyrus during reward anticipation activities, according to another neuroimaging research(44).

- **Biofeedback and wearable devices**

## 6. Challenges and Limitations in Treatment

Treatment of Skin Picking Disorder (SPD) faces several key challenges. The condition is often underdiagnosed due to stigma and lack of awareness. Its symptoms vary widely, and it frequently co-occurs with other psychiatric disorders, complicating treatment. While cognitive-behavioral therapy (CBT), particularly habit reversal training (HRT), is effective, access to trained therapists is limited. Pharmacological options like SSRIs and N-acetylcysteine show mixed results, with no FDA-approved medications available. Relapse rates are high, and the chronic nature of SPD requires long-term strategies that are not well established. Additionally, limited understanding of its neurobiology and a lack of standardized diagnostic tools hinder progress in developing targeted therapies.

## 7. Future Directions and Research Gaps

Despite growing recognition of Skin Picking Disorder (SPD), significant research gaps remain. Future studies should focus on identifying specific neurobiological markers to better understand its underlying mechanisms. Large-scale clinical trials are needed to evaluate the long-term effectiveness of pharmacological and psychotherapeutic treatments, including newer agents and digital interventions. Development of standardized diagnostic criteria and outcome measures will enhance research consistency. Additionally, greater exploration of early intervention strategies, relapse prevention, and culturally sensitive approaches can improve treatment outcomes. Increasing public and professional awareness is also critical to reducing stigma and improving diagnosis and access to care.

## 8. Conclusion

Skin Picking Disorder (Excoriation Disorder) is a complex and often overlooked condition that significantly impacts quality of life. Although progress has been made in understanding its clinical features and potential treatments, challenges persist due to limited evidence-based options, high relapse rates, and insufficient awareness. Effective management requires a multidisciplinary approach, combining psychotherapeutic and pharmacological strategies tailored to individual needs. Future research aimed at uncovering its neurobiological underpinnings, standardizing assessment tools, and improving access to care will be essential in advancing treatment and outcomes for those affected.

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