Neurodevelopmental disorders. In neurodevelopmental disorders, hair pulling may meet the definition of stereotypies (e.g., in stereotypic movement disorder). Tics (in tic disorders) rarely lead to hair pulling.

Psychotic disorder. Individuals with a psychotic disorder may remove hair in response to a delusion or hallucination. Trichotillomania is not diagnosed in such cases.

Another medical condition. Trichotillomania is not diagnosed if the hair pulling or hair loss is attributable to another medical condition (e.g., inflammation of the skin or other dermatological conditions). Other causes of scarring alopecia (e.g., alopecia areata, androgenic alopecia, telogen effluvium) or nonscarring alopecia (e.g., chronic discoid lupus erythematosus, lichen planopilaris, central centrifugal cicatricial alopecia, pseudopelade, folliculitis decalvans, dissecting folliculitis, acne keloidalis nuchae) should be considered in individuals with hair loss who deny hair pulling. Skin biopsy or dermoscopy can be used to differentiate individuals with trichotillomania from those with dermatological disorders.

Substance-related disorders. Hair-pulling symptoms may be exacerbated by certain substances—for example, stimulants—but it is less likely that substances are the primary cause of persistent hair pulling.

Comorbidity

Trichotillomania is often accompanied by other mental disorders, most commonly major depressive disorder and excoriation (skin-picking) disorder. Repetitive body-focused symptoms other than hair pulling or skin picking (e.g. nail biting) occur in the majority of individuals with trichotillomania and may deserve an additional diagnosis of other specified obsessive-compulsive and related disorder (i.e., body-focused repetitive behavior disorder).

Excoriation (Skin-Picking) Disorder

Diagnostic Criteria **698.4 (L98.1)**

A. Recurrent skin picking resulting in skin lesions.
B. Repeated attempts to decrease or stop skin picking.
C. The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The skin picking is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., scabies).
E. The skin picking is not better explained by symptoms of another mental disorder (e.g., delusions or tactile hallucinations in a psychotic disorder, attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder, stereotypies in stereotypic movement disorder, or intention to harm oneself in nonsuicidal self-injury).

Diagnostic Features

The essential feature of excoriation (skin-picking) disorder is recurrent picking at one's own skin (Criterion A). The most commonly picked sites are the face, arms, and hands, but many individuals pick from multiple body sites. Individuals may pick at healthy skin, at minor skin irregularities, at lesions such as pimples or calluses, or at scabs from previous picking. Most individuals pick with their fingernails, although many use tweezers, pins, or other objects. In addition to skin picking, there may be skin rubbing, squeezing, lancing, and biting. Individuals with excoriation disorder often spend significant amounts of time on their picking behavior, sometimes several hours per day, and such skin picking may

endure for months or years. Criterion A requires that skin picking lead to skin lesions, although individuals with this disorder often attempt to conceal or camouflage such lesions (e.g., with makeup or clothing). Individuals with excoriation disorder have made repeated attempts to decrease or stop skin picking (Criterion B).

Criterion C indicates that skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. The term *distress* includes negative affects that may be experienced by individuals with skin picking, such as feeling a loss of control, embarrassment, and shame. Significant impairment may occur in several different areas of functioning (e.g., social, occupational, academic, and leisure), in part because of avoidance of social situations.

Associated Features Supporting Diagnosis

Skin picking may be accompanied by a range of behaviors or rituals involving skin or scabs. Thus, individuals may search for a particular kind of scab to pull, and they may examine, play with, or mouth or swallow the skin after it has been pulled. Skin picking may also be preceded or accompanied by various emotional states. Skin picking may be triggered by feelings of anxiety or boredom, may be preceded by an increasing sense of tension (either immediately before picking the skin or when attempting to resist the urge to pick), and may lead to gratification, pleasure, or a sense of relief when the skin or scab has been picked. Some individuals report picking in response to a minor skin irregularity or to relieve an uncomfortable bodily sensation. Pain is not routinely reported to accompany skin picking. Some individuals engage in skin picking that is more focused (i.e., with preceding tension and subsequent relief), whereas others engage in more automatic picking (i.e., when skin picking occurs without preceding tension and without full awareness), and many have a mix of both behavioral styles. Skin picking does not usually occur in the presence of other individuals, except immediate family members. Some individuals report picking the skin of others.

Prevalence

In the general population, the lifetime prevalence for excoriation disorder in adults is 1.4% or somewhat higher. Three-quarters or more of individuals with the disorder are female. This likely reflects the true gender ratio of the condition, although it may also reflect differential treatment seeking based on gender or cultural attitudes regarding appearance.

Development and Course

Although individuals with excoriation disorder may present at various ages, the skin picking most often has onset during adolescence, commonly coinciding with or following the onset of puberty. The disorder frequently begins with a dermatological condition, such as acne. Sites of skin picking may vary over time. The usual course is chronic, with some waxing and waning if untreated. For some individuals, the disorder may come and go for weeks, months, or years at a time.

Risk and Prognostic Factors

Genetic and physiological. Excoriation disorder is more common in individuals with obsessive-compulsive disorder (OCD) and their first-degree family members than in the general population.

Diagnostic Markers

Most individuals with excoriation disorder admit to skin picking; therefore, dermatopathological diagnosis is rarely required. However, the disorder may have characteristic features on histopathology.

Functional Consequences of Excoriation (Skin-Picking) Disorder

Excoriation disorder is associated with distress as well as with social and occupational impairment. The majority of individuals with this condition spend at least 1 hour per day picking, thinking about picking, and resisting urges to pick. Many individuals report avoiding social or entertainment events as well as going out in public. A majority of individuals with the disorder also report experiencing work interference from skin picking on at least a daily or weekly basis. A significant proportion of students with excoriation disorder report having missed school, having experienced difficulties managing responsibilities at school, or having had difficulties studying because of skin picking. Medical complications of skin picking include tissue damage, scarring, and infection and can be life-threatening. Rarely, synovitis of the wrists due to chronic picking has been reported. Skin picking often results in significant tissue damage and scarring. It frequently requires antibiotic treatment for infection, and on occasion it may require surgery.

Differential Diagnosis

Psychotic disorder. Skin picking may occur in response to a delusion (i.e., parasitosis) or tactile hallucination (i.e., formication) in a psychotic disorder. In such cases, excoriation disorder should not be diagnosed.

Other obsessive-compulsive and related disorders. Excessive washing compulsions in response to contamination obsessions in individuals with OCD may lead to skin lesions, and skin picking may occur in individuals with body dysmorphic disorder who pick their skin solely because of appearance concerns; in such cases, excoriation disorder should not be diagnosed. The description of body-focused repetitive behavior disorder in other specified obsessive-compulsive and related disorder excludes individuals whose symptoms meet diagnostic criteria for excoriation disorder.

Neurodevelopmental disorders. While stereotypic movement disorder may be characterized by repetitive self-injurious behavior, onset is in the early developmental period. For example, individuals with the neurogenetic condition Prader-Willi syndrome may have early onset of skin picking, and their symptoms may meet criteria for stereotypic movement disorder. While tics in individuals with Tourette's disorder may lead to self-injury, the behavior is not tic-like in excoriation disorder.

Somatic symptom and related disorders. Excoriation disorder is not diagnosed if the skin lesion is primarily attributable to deceptive behaviors in factitious disorder.

Other disorders. Excoriation disorder is not diagnosed if the skin picking is primarily attributable to the intention to harm oneself that is characteristic of nonsuicidal self-injury.

Other medical conditions. Excoriation disorder is not diagnosed if the skin picking is primarily attributable to another medical condition. For example, scabies is a dermatological condition invariably associated with severe itching and scratching. However, excoriation disorder may be precipitated or exacerbated by an underlying dermatological condition. For example, acne may lead to some scratching and picking, which may also be associated with comorbid excoriation disorder. The differentiation between these two clinical situations (acne with some scratching and picking vs. acne with comorbid excoriation disorder) requires an assessment of the extent to which the individual's skin picking has become independent of the underlying dermatological condition.

Substance/medication-induced disorders. Skin-picking symptoms may also be induced by certain substances (e.g., cocaine), in which case excoriation disorder should not be diagnosed. If such skin picking is clinically significant, then a diagnosis of substance/medication-induced obsessive-compulsive and related disorder should be considered.

Comorbidity

Excoriation disorder is often accompanied by other mental disorders. Such disorders include OCD and trichotillomania (hair-pulling disorder), as well as major depressive disorder. Repetitive body-focused symptoms other than skin picking and hair pulling (e.g., nail biting) occur in many individuals with excoriation disorder and may deserve an additional diagnosis of other specified obsessive-compulsive and related disorder (i.e., body-focused repetitive behavior disorder).

Substance/Medication-Induced Obsessive-Compulsive and Related Disorder

Diagnostic Criteria

A. Obsessions, compulsions, skin picking, hair pulling, other body-focused repetitive behaviors, or other symptoms characteristic of the obsessive-compulsive and related disorders predominate in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

   1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
   2. The involved substance/medication is capable of producing the symptoms in Criterion A.

C. The disturbance is not better explained by an obsessive-compulsive and related disorder that is not substance/medication-induced. Such evidence of an independent obsessive-compulsive and related disorder could include the following:

   The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced obsessive-compulsive and related disorder (e.g., a history of recurrent non-substance/medication-related episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: This diagnosis should be made in addition to a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and are sufficiently severe to warrant clinical attention.

Coding note: The ICD-9-CM and ICD-10-CM codes for the [specific substance/medication]-induced obsessive-compulsive and related disorders are indicated in the table below. Note that the ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. If a mild substance use disorder is comorbid with the substance-induced obsessive-compulsive and related disorder, the 4th position character is "1," and the clinician should record "mild [substance] use disorder" before the substance-induced obsessive-compulsive and related disorder (e.g., "mild cocaine use disorder with cocaine-induced obsessive-compulsive and related disorder"). If a moderate or severe substance use disorder is comorbid with the substance-induced obsessive-compulsive and related disorder, the 4th position character is "2," and the clinician should record "moderate [substance] use disorder" or "severe [substance] use disorder," depending on the severity of the comorbid substance use disorder. If there is no comorbid

substance use disorder (e.g., after a one-time heavy use of the substance), then the 4th position character is "9," and the clinician should record only the substance-induced obsessive-compulsive and related disorder.

		ICD-10-CM		
	ICD-9-CM	With use disorder, mild	With use disorder, moderate or severe	Without use disorder
Amphetamine (or other stimulant)	292.89	F15.188	F15.288	F15.988
Cocaine	292.89	F14.188	F14.288	F14.988
Other (or unknown) substance	292.89	F19.188	F19.288	F19.988

Specify if (see Table 1 in the chapter "Substance-Related and Addictive Disorders" for diagnoses associated with substance class):

With onset during intoxication: If the criteria are met for intoxication with the substance and the symptoms develop during intoxication.

With onset during withdrawal: If criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal.

With onset after medication use: Symptoms may appear either at initiation of medication or after a modification or change in use.

Recording Procedures

ICD-9-CM. The name of the substance/medication-induced obsessive-compulsive and related disorder begins with the specific substance (e.g., cocaine) that is presumed to be causing the obsessive-compulsive and related symptoms. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class. For substances that do not fit into any of the classes, the code for "other substance" should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the category "unknown substance" should be used.

The name of the disorder is followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal, with onset after medication use). Unlike the recording procedures for ICD-10-CM, which combine the substance-induced disorder and substance use disorder into a single code, for ICD-9-CM a separate diagnostic code is given for the substance use disorder. For example, in the case of repetitive behaviors occurring during intoxication in a man with a severe cocaine use disorder, the diagnosis is 292.89 cocaine-induced obsessive-compulsive and related disorder, with onset during intoxication. An additional diagnosis of 304.20 severe cocaine use disorder is also given. When more than one substance is judged to play a significant role in the development of the obsessive-compulsive and related disorder, each should be listed separately.

ICD-10-CM. The name of the substance/medication-induced obsessive-compulsive and related disorder begins with the specific substance (e.g., cocaine) that is presumed to be causing the obsessive-compulsive and related symptoms. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class and presence or absence of a comorbid substance use disorder. For substances that do not fit into any of the classes, the code for "other substance" with no comorbid substance use should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the category "unknown substance" with no comorbid substance use should be used.

When recording the name of the disorder, the comorbid substance use disorder (if any) is listed first, followed by the word "with," followed by the name of the substance-induced obsessive-compulsive and related disorder, followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal, with onset after medication use). For example, in the case of repetitive behaviors occurring during intoxication in a man with a severe cocaine use disorder, the diagnosis is F14.288 severe cocaine use disorder with cocaine-induced obsessive-compulsive and related disorder, with onset during intoxication. A separate diagnosis of the comorbid severe cocaine use disorder is not given. If the substance-induced obsessive-compulsive and related disorder occurs without a comorbid substance use disorder (e.g., after a one-time heavy use of the substance), no accompanying substance use disorder is noted (e.g., F15.988 amphetamine-induced obsessive-compulsive and related disorder, with onset during intoxication). When more than one substance is judged to play a significant role in the development of the obsessive-compulsive and related disorder, each should be listed separately.

Diagnostic Features

The essential features of substance/medication-induced obsessive-compulsive and related disorder are prominent symptoms of an obsessive-compulsive and related disorder (Criterion A) that are judged to be attributable to the effects of a substance (e.g., drug of abuse, medication). The obsessive-compulsive and related disorder symptoms must have developed during or soon after substance intoxication or withdrawal or after exposure to a medication or toxin, and the substance/medication must be capable of producing the symptoms (Criterion B). Substance/medication-induced obsessive-compulsive and related disorder due to a prescribed treatment for a mental disorder or general medical condition must have its onset while the individual is receiving the medication. Once the treatment is discontinued, the obsessive-compulsive and related disorder symptoms will usually improve or remit within days to several weeks to 1 month (depending on the half-life of the substance/medication). The diagnosis of substance/medication-induced obsessive-compulsive and related disorder should not be given if onset of the obsessive-compulsive and related disorder symptoms precedes the substance intoxication or medication use, or if the symptoms persist for a substantial period of time, usually longer than 1 month, from the time of severe intoxication or withdrawal. If the obsessive-compulsive and related disorder symptoms persist for a substantial period of time, other causes for the symptoms should be considered. The substance/medication-induced obsessive-compulsive and related disorder diagnosis should be made in addition to a diagnosis of substance intoxication only when the symptoms in Criterion A predominate in the clinical picture and are sufficiently severe to warrant independent clinical attention

Associated Features Supporting Diagnosis

Obsessions, compulsions, hair pulling, skin picking, or other body-focused repetitive behaviors can occur in association with intoxication with the following classes of substances: stimulants (including cocaine) and other (or unknown) substances. Heavy metals and toxins may also cause obsessive-compulsive and related disorder symptoms. Laboratory assessments (e.g., urine toxicology) may be useful to measure substance intoxication as part of an assessment for obsessive-compulsive and related disorders.

Prevalence

In the general population, the very limited data that are available indicate that substance-induced obsessive-compulsive and related disorder is very rare.

Differential Diagnosis

Substance intoxication. Obsessive-compulsive and related disorder symptoms may occur in substance intoxication. The diagnosis of the substance-specific intoxication will usu-