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Más Allá de la Lesión Cutánea: Mecanismos Psicopatológicos, Diagnóstico Diferencial y Manejo Interdisciplinario del Trastorno de Excoriación y la Dermatitis Artefacta

Beyond Cutaneous Injury: Psychopathological Mechanisms, Differential Diagnosis, and Interdisciplinary Management of Excoriation Disorder and Dermatitis Artefacta

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RESUMEN

Las dermatosis autoinfligidas, particularmente el trastorno de excoriación y la dermatitis artefacta, constituyen condiciones clínicas complejas caracterizadas por la interacción entre mecanismos psicopatológicos, alteraciones conductuales y lesiones cutáneas recurrentes. Esta revisión narrativa tuvo como objetivo analizar los factores psicológicos, las características dermatológicas, las dificultades diagnósticas y las estrategias terapéuticas interdisciplinarias asociadas con estos trastornos, integrando evidencia científica internacional y contribuciones latinoamericanas. Se examinaron publicaciones relacionadas con epidemiología, comorbilidades psiquiátricas, manifestaciones clínicas, diagnóstico diferencial y resultados terapéuticos mediante un enfoque descriptivo y comparativo. Los hallazgos epidemiológicos identificaron una prevalencia actual del trastorno de excoriación del 2.1%, una prevalencia de por vida del 3.1% y una prevalencia agrupada del 3.45% en diferentes investigaciones. La ansiedad, la desregulación emocional, la compulsividad y las dificultades en la inhibición conductual destacaron como factores relacionados con la persistencia de los síntomas. El análisis diagnóstico evidenció diferencias importantes entre el trastorno de excoriación y la dermatitis artefacta, especialmente en el reconocimiento de la conducta, el contexto psicológico y las características de las lesiones. La evidencia terapéutica respaldó las intervenciones conductuales, incluyendo la inversión del hábito y la terapia cognitivo-conductual, mientras que las investigaciones farmacológicas mostraron resultados favorables, aunque variables, con N-acetilcisteína. El abordaje interdisciplinario entre dermatología, psiquiatría y psicología se identificó como una estrategia clínicamente relevante para atender las complicaciones cutáneas, las comorbilidades psiquiátricas y las conductas recurrentes. Sin embargo, la heterogeneidad metodológica, el seguimiento limitado y la insuficiente representación regional restringen la generalización de los hallazgos. Se concluye que la diferenciación diagnóstica precisa, la intervención psicológica individualizada y la atención clínica coordinada constituyen componentes fundamentales del manejo integral de estas dermatosis. Se requieren investigaciones multicéntricas que fortalezcan la evidencia terapéutica y mejoren el acceso a servicios especializados de psicodermatología.

PALABRAS CLAVE

Dermatosis autoinfligidas, trastorno de excoriación, trastorno por pellizcado de la piel, dermatitis artefacta, psicodermatología, psicopatología, comorbilidad psiquiátrica, terapia cognitivo-conductual, manejo interdisciplinario, diagnóstico dermatológico.

ABSTRACT

Self-inflicted dermatoses, particularly excoriation disorder and dermatitis artefacta, represent complex clinical conditions involving interactions between psychopathological mechanisms, behavioral disturbances, and recurrent cutaneous injury. This narrative review aimed to analyze the psychological factors, dermatological characteristics, diagnostic challenges, and interdisciplinary therapeutic strategies associated with these disorders, integrating international scientific evidence with contributions from Latin America. Relevant publications addressing epidemiology, psychiatric comorbidities, clinical manifestations, differential diagnosis, and treatment outcomes were examined through a descriptive and comparative approach. Epidemiological findings identified a current prevalence of excoriation disorder of 2.1%, a lifetime prevalence of 3.1%, and a pooled prevalence of 3.45% across different investigations. Anxiety, emotional dysregulation, compulsivity, and difficulties in behavioral inhibition emerged as relevant factors associated with symptom persistence. Diagnostic analysis revealed important differences between excoriation disorder and dermatitis artefacta, particularly regarding behavioral awareness, psychological context, and lesion characteristics. Therapeutic evidence supported behavioral interventions, including habit reversal training and cognitive behavioral therapy, while pharmacological investigations demonstrated favorable but variable outcomes with N-acetylcysteine. Interdisciplinary management involving dermatology, psychiatry, and psychology was identified as a clinically relevant approach for addressing cutaneous complications, psychiatric comorbidities, and recurrent behaviors. Nevertheless, methodological heterogeneity, limited long-term follow-up, and insufficient regional representation restrict the generalizability of available findings. In conclusion, accurate diagnostic differentiation, individualized psychological intervention, and coordinated clinical management constitute fundamental components of comprehensive care for self-inflicted dermatoses. Further multicenter investigations are necessary to strengthen therapeutic evidence and improve accessibility to specialized psychodermatological services.

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KEYWORDS

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INTRODUCCIÓN

The relationship between psychological functioning and dermatological disease represents one of the most complex areas of contemporary clinical medicine, particularly when alterations in emotional regulation, behavioral control, and psychiatric functioning contribute directly to the development or persistence of cutaneous lesions. Within this context, self-inflicted dermatoses constitute a heterogeneous group of clinical conditions in which repetitive manipulation, scratching, picking, rubbing, or deliberate injury produces structural damage to the skin. Although these manifestations may initially resemble conventional inflammatory, infectious, or traumatic dermatological disorders, their underlying mechanisms frequently involve psychological distress, dysfunctional behavioral patterns, and psychiatric comorbidities that cannot be adequately addressed through dermatological interventions alone. Consequently, the evaluation of these conditions requires an approach that integrates cutaneous examination with psychiatric assessment and psychological understanding, recognizing the skin not merely as an anatomical structure but also as a potential site of expression of emotional and behavioral disturbances (Gieler et al., 2013; Torales et al., 2020; Jafferany et al., 2020).

Among the different forms of self-inflicted dermatoses, excoriation disorder, also referred to as skin-picking disorder, occupies a particularly relevant position because of its clinical frequency, persistent course, and considerable psychosocial consequences. This condition is characterized by recurrent manipulation of the skin resulting in visible tissue damage, accompanied by repeated unsuccessful attempts to decrease or discontinue the behavior and clinically significant distress or impairment. Its recognition as a distinct condition within the spectrum of obsessive-compulsive and related disorders has contributed to a more precise understanding of its diagnostic characteristics and underlying behavioral mechanisms. Nevertheless, the relationship between excoriation disorder and other self-inflicted dermatological conditions remains complex, especially when patients present with overlapping manifestations, incomplete awareness of their behavior, or psychiatric symptoms that modify the clinical presentation. The distinction between excoriation disorder, psychogenic excoriations, dermatitis artefacta, and other factitious or repetitive skin-damaging behaviors is therefore essential to avoid diagnostic inaccuracies and inappropriate therapeutic strategies (Arnold et al., 2001; Gieler et al., 2013; Lochner et al., 2017).

The epidemiological relevance of excoriation disorder has become increasingly evident as population-based investigations and systematic reviews have demonstrated that repetitive pathological skin picking affects a meaningful proportion of the general population. Grant and Chamberlain (2020), in a study involving 10,169 adults in the United States, identified a current prevalence of 2.1% and a lifetime prevalence of 3.1%, highlighting the considerable frequency of a condition that may remain unrecognized in routine clinical practice. Subsequently, Farhat et al. (2023), through a systematic review and meta-analysis involving 19 studies and 38,038 participants, estimated a pooled prevalence of 3.45%, with a greater occurrence among women than men. These findings suggest that excoriation disorder should not be regarded as an exceptional psychiatric manifestation restricted to specialized clinical settings, but rather as a relevant public health concern that warrants improved recognition across dermatology, psychiatry, primary care, and psychological services. At the same time, differences in diagnostic criteria, assessment instruments, geographical representation, and study populations indicate that epidemiological estimates require careful interpretation and cannot automatically be generalized to all healthcare environments.

Beyond its frequency, excoriation disorder is distinguished by the heterogeneity of its behavioral manifestations. Skin picking may occur in response to emotional tension, anxiety, boredom, frustration, or perceived imperfections in the skin, while in other circumstances it develops with limited immediate awareness during sedentary activities or periods

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of reduced attentional engagement. Some individuals describe a progressive urge to manipulate a particular cutaneous area, followed by temporary relief or gratification, whereas others report repetitive behavior that becomes increasingly difficult to control despite pain, bleeding, or visible tissue destruction. These different behavioral patterns suggest that excoriation disorder cannot be adequately explained by a single psychological mechanism. Rather, its manifestations may involve interacting processes of impulsivity, compulsivity, emotional dysregulation, reinforcement learning, and difficulties in behavioral inhibition. Understanding these processes is particularly important because two patients with similar dermatological findings may present substantially different psychological triggers, levels of insight, and therapeutic needs (Misery et al., 2012; Grant & Chamberlain, 2017; Torales et al., 2020).

The psychopathological characteristics associated with self-inflicted cutaneous injury have generated considerable interest because they challenge the traditional separation between psychiatric symptoms and physical disease. Clinical investigations have identified associations between pathological skin picking and anxiety disorders, depressive symptoms, obsessive-compulsive manifestations, and difficulties with impulse control. Calikuşu et al. (2003) emphasized the relationship between psychogenic excoriation and psychiatric disorders, supporting the importance of psychological assessment in patients whose dermatological manifestations cannot be fully explained by an identifiable organic condition. Similarly, Grant and Chamberlain (2017) observed that greater symptom severity in excoriation disorder was associated with increased impulsivity, anxiety, depressive symptoms, and functional impairment. These findings support a multidimensional understanding in which psychiatric comorbidity may influence both the frequency of skin manipulation and the consequences of the resulting lesions. However, such associations should not be interpreted as evidence that every patient shares the same psychiatric profile or that anxiety and depression necessarily precede the onset of the dermatological manifestations.

The role of emotional regulation is especially relevant in understanding the persistence of repetitive skin-damaging behaviors. From a behavioral perspective, manipulation of the skin may temporarily reduce uncomfortable internal experiences, generating a reinforcing cycle in which short-term emotional relief contributes to the repetition of an ultimately harmful action. Over time, this mechanism may become increasingly automatic, reducing the individual's perceived ability to interrupt the behavior even when its physical and social consequences are recognized. In other patients, attention directed toward minor cutaneous irregularities, acne lesions, scabs, or perceived imperfections may provoke repetitive attempts to achieve a sensation of smoothness or completeness. These processes demonstrate that skin picking may be maintained by different combinations of sensory stimulation, emotional reinforcement, and cognitive expectations. Consequently, identifying the circumstances preceding each episode, the immediate consequences of manipulation, and the patient's interpretation of the behavior may provide clinically relevant information for psychological intervention (Arnold et al., 2001; Torales et al., 2020; Lochner et al., 2017).

From the dermatological perspective, the consequences of recurrent skin manipulation extend considerably beyond superficial excoriations. Repeated disruption of the epidermal barrier may produce erosions, crusts, bleeding, secondary infections, post-inflammatory pigmentary alterations, and persistent scarring. Depending on the intensity and chronicity of the behavior, lesions may vary in depth, distribution, and healing stage, generating a polymorphic clinical appearance that can complicate differential diagnosis. The affected areas frequently include regions readily accessible to the hands, particularly the face, upper extremities, and other exposed or easily reached anatomical sites. Nevertheless, lesion distribution alone is insufficient to establish a psychiatric diagnosis, because inflammatory dermatoses, pruritic disorders, neuropathic symptoms, and other medical conditions may generate similar patterns of cutaneous damage. A careful examination of primary and secondary lesions, together with an assessment of underlying dermatological disease, remains essential before attributing tissue injury predominantly to psychological or behavioral factors (Gieler et al., 2013; Lavery et al., 2018; Jafferany et al., 2020).

Within the broader spectrum of self-inflicted skin conditions, dermatitis artefacta represents a particularly challenging diagnostic entity. Unlike excoriation disorder, in which the patient commonly recognizes recurrent skin picking but experiences difficulty controlling it, dermatitis artefacta involves the production of cutaneous lesions within a factitious clinical presentation, frequently accompanied by complex psychological motivations and limited disclosure of the circumstances surrounding the injuries. The lesions may exhibit unusual configurations, sharply demarcated borders, geometric patterns, or distributions inconsistent with familiar inflammatory or infectious dermatoses. Nevertheless, none of these characteristics is independently diagnostic, and the patient's awareness of the behavior, underlying

psychological needs, and relationship with medical care may vary considerably. These distinctions are important because inappropriate confrontation or an assumption of intentional deception may damage the therapeutic relationship, discourage follow-up, and increase the likelihood of fragmented care (Mohandas et al., 2013; Lavery et al., 2018; Torales et al., 2023).

The diagnostic complexity of dermatitis artefacta also reflects the limitations of relying exclusively on visible skin abnormalities. Patients may undergo repeated consultations, extensive diagnostic investigations, or multiple therapeutic interventions before an integrated assessment identifies the contribution of behavioral and psychological mechanisms. Furthermore, the presence of self-inflicted lesions does not exclude simultaneous organic dermatological disease, making it necessary to consider infectious, inflammatory, autoimmune, bullous, traumatic, and other relevant differential diagnoses according to the clinical findings. Dermatological examination, lesion documentation, evaluation of anatomical accessibility, and appropriately selected complementary investigations may help clarify uncertain presentations. In specific circumstances, dermoscopy, laboratory studies, microbiological evaluation, or skin biopsy may be justified to exclude alternative conditions rather than to establish a psychiatric explanation through exclusion alone. The objective of this assessment is not simply to identify the origin of tissue damage, but to construct a clinically defensible diagnosis that avoids unnecessary investigations while preserving patient dignity and therapeutic trust (Gieler et al., 2013; Lavery et al., 2018; Torales et al., 2023).

An additional challenge lies in the inconsistent terminology historically used to describe self-inflicted dermatological lesions. Expressions such as neurotic excoriations, psychogenic excoriations, skin-picking syndrome, factitial dermatitis, and dermatitis artefacta have sometimes been employed interchangeably despite representing different behavioral, diagnostic, and psychopathological phenomena. Gieler et al. (2013), in a position paper developed by the European Society for Dermatology and Psychiatry, emphasized the importance of standardized terminology and classification to distinguish the mechanisms underlying self-inflicted lesions. Such distinctions have practical consequences because repetitive behavior driven by difficult-to-control urges may require therapeutic strategies different from those appropriate for factitious presentations, psychotic disorders, or deliberate self-injury associated with other psychiatric conditions. Diagnostic precision therefore depends not only on describing the dermatological morphology, but also on evaluating intentionality, awareness, motivation, associated symptoms, and the broader psychiatric context without making premature assumptions about the patient's behavior.

The psychological consequences of self-inflicted dermatoses further contribute to their clinical significance. Visible lesions affecting the face, hands, or other exposed regions may produce embarrassment, social withdrawal, reduced self-esteem, and avoidance of interpersonal situations. These experiences can aggravate pre-existing psychiatric symptoms and potentially reinforce repetitive skin manipulation through cycles of distress and behavioral repetition. Consequently, the relationship between emotional suffering and dermatological injury may become bidirectional, in which psychological factors contribute to the persistence of lesions while the lesions themselves generate additional distress. This interaction makes it difficult to distinguish primary psychopathological mechanisms from secondary emotional consequences in cross-sectional clinical assessments. The importance of evaluating both dimensions has been supported by investigations demonstrating associations between excoriation severity, anxiety, depressive symptoms, and functional impairment, suggesting that effective clinical assessment should extend beyond lesion counts or visible healing alone (Grant & Chamberlain, 2017; Grant & Chamberlain, 2020; Torales et al., 2020).

Psychiatric and psychological assessment must therefore form an integral component of the diagnostic process. A comprehensive evaluation should investigate the onset and progression of skin manipulation, emotional and environmental triggers, the degree of awareness during episodes, previous attempts to resist the behavior, and its impact on occupational, academic, family, and social functioning. It should also explore relevant psychiatric comorbidities, including anxiety, depressive disorders, obsessive-compulsive symptoms, body-image concerns, substance-related problems, and other conditions when clinically indicated. Particularly important is the distinction between repetitive skin picking without an intention to cause injury for its own sake and other forms of self-injurious behavior, including those associated with suicidal intent or different psychological functions. This differentiation has implications for risk assessment, treatment planning, and the urgency of psychiatric intervention. Rather than relying on isolated diagnostic labels, the assessment should establish an individualized formulation connecting cutaneous findings with emotional, cognitive, behavioral, and environmental determinants (Misery et al., 2012; Gieler et al., 2013; Jafferany et al., 2020).

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The treatment of excoriation disorder has evolved as behavioral interventions have gained recognition as important therapeutic options. Habit reversal training, often incorporated into broader cognitive behavioral approaches, seeks to improve awareness of repetitive behaviors, identify antecedent situations, and develop alternative responses that interfere with skin manipulation. Teng et al. (2006) provided early evidence supporting habit reversal techniques in chronic skin picking, while subsequent systematic evaluations have examined behavioral and pharmacological strategies across different patient populations. Schumer et al. (2016), in a systematic review and meta-analysis of treatment studies, found that behavioral interventions demonstrated advantages over inactive control conditions, whereas the randomized evidence for several pharmacological approaches was less conclusive. These findings underline the importance of distinguishing improvements observed during treatment from effects established through adequately controlled comparisons. They also suggest that behavioral therapy should occupy a central position in discussions of evidence-based treatment, while recognizing differences in treatment accessibility, patient preferences, comorbidities, and clinical severity.

More recent research has explored adaptations of behavioral treatment designed to improve accessibility and address emotional processes involved in symptom persistence. Acceptance-enhanced behavior therapy combines behavioral strategies with approaches aimed at increasing psychological flexibility and reducing maladaptive responses to internal experiences. Asplund et al. (2025), in a randomized controlled trial, reported improvements in skin-picking symptoms following therapist-guided internet-delivered acceptance-enhanced behavior therapy compared with a waiting-list condition. Although these findings support the potential of remotely delivered interventions, questions remain regarding long-term effectiveness, relapse prevention, and generalizability to populations with different levels of technological access or psychiatric complexity. Loftus et al. (2025) further examined nonpharmacological treatment options, highlighting continued interest in behavioral and psychological interventions. Together, these investigations demonstrate the relevance of therapeutic approaches that address the mechanisms maintaining repetitive skin manipulation rather than focusing exclusively on the resulting dermatological injuries.

Pharmacological interventions have also been investigated, particularly in patients with persistent symptoms, substantial impairment, or associated psychiatric conditions. Selective serotonin reuptake inhibitors and other psychotropic agents have been considered because of the relationship between excoriation disorder and obsessive-compulsive or affective symptoms. However, treatment responses have varied across studies, and the evidence supporting particular medications remains more limited than that available for selected behavioral interventions. Grant et al. (2016), in a randomized clinical trial, reported that N-acetylcysteine produced greater reductions in skin-picking symptoms than placebo over a 12-week treatment period, providing evidence for the potential relevance of glutamatergic modulation. Nevertheless, individual study findings should not be interpreted as establishing a universally effective pharmacological regimen. Systematic reviews have emphasized the need for additional controlled trials, larger clinical samples, and longer follow-up periods to clarify treatment selection, durability of response, and the role of medication within comprehensive care (Schumer et al., 2016; Lochner et al., 2017).

The therapeutic management of dermatitis artefacta presents additional challenges because conventional interventions directed toward repetitive skin picking may not adequately address the underlying psychological and interpersonal mechanisms of factitious presentations. Establishing a stable clinical relationship, avoiding punitive confrontation, and facilitating progressive engagement with mental health services are particularly important. Mohandas et al. (2013), through an analysis of patients managed in a specialized psychodermatology service, described favorable clinical outcomes within a multidisciplinary model involving dermatological and psychological or psychiatric expertise. More recently, Gerlero et al. (2026) reported the clinical characteristics and management experiences of 42 patients with dermatitis artefacta at a Brazilian university medical center, emphasizing the importance of the clinician-patient relationship and the difficulties associated with psychiatric referral and continuity of care. These investigations contribute to understanding the practical barriers encountered in real-world settings, although their observational nature limits conclusions regarding the comparative effectiveness of specific treatment approaches.

The importance of interdisciplinary management becomes particularly evident when considering that dermatological treatment and psychiatric intervention address different but interconnected dimensions of disease. Dermatologists are responsible for identifying and treating cutaneous injury, preventing complications, evaluating alternative diagnoses, and monitoring tissue recovery. Psychiatrists contribute to diagnostic clarification, identification and management of

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psychiatric comorbidities, and consideration of pharmacotherapy when appropriate. Psychologists provide behavioral assessment, psychological formulation, and structured interventions directed toward maladaptive habits, emotional regulation, and coping strategies. When these contributions are integrated into a coordinated care pathway, clinical management can address both the physical consequences of repetitive injury and the processes that maintain its recurrence. However, while specialized interdisciplinary models are supported by clinical experience and observational evidence, further comparative research is needed to establish their effectiveness across different healthcare systems and patient populations (Mohandas et al., 2013; Jafferany et al., 2020; Torales et al., 2023).

The international relevance of this subject is reinforced by differences in access to specialized psychodermatology services, mental health resources, and continuity of care. Much of the published evidence originates from European and North American settings, where specialized clinical services and structured behavioral interventions have contributed to the development of diagnostic and therapeutic approaches. Nevertheless, research participation from Latin America has expanded the geographical representation of the field. Torales et al. (2020), through collaborative work involving investigators from Paraguay, Brazil, and other countries, provided an updated discussion of the psychiatric and dermatological dimensions of excoriation disorder. Similarly, Farhat et al. (2023), whose research included Brazilian academic participation, contributed to international epidemiological understanding through a systematic review and meta-analysis. The Brazilian clinical series published by Gerlero et al. (2026) offers additional regional evidence concerning dermatitis artefacta in a university healthcare environment. These contributions are particularly relevant because locally generated clinical data may help identify barriers to diagnosis and treatment that are not fully represented in studies from other healthcare systems.

Despite these advances, important knowledge gaps persist in Latin America and other regions where multidisciplinary psychodermatology services may be unevenly distributed. Available studies do not yet establish how variations in healthcare accessibility, socioeconomic circumstances, cultural interpretations of mental illness, or referral pathways influence clinical outcomes across the region. Moreover, the frequent separation of dermatological and psychiatric services may create practical difficulties for coordinated follow-up, although the extent of these barriers requires further empirical investigation. Research that includes diverse populations, validated assessment instruments, and clearly defined clinical outcomes is necessary to determine whether approaches developed in specialized centers can be adapted effectively to different institutional environments. Regional participation is therefore important not simply for geographical representation, but for improving the external validity, clinical applicability, and accessibility of emerging psychodermatological knowledge (Torales et al., 2020; Farhat et al., 2023; Gerlero et al., 2026).

Another unresolved issue concerns the relationship between diagnostic accuracy and therapeutic effectiveness. Although excoriation disorder and dermatitis artefacta may produce overlapping patterns of cutaneous damage, the psychological mechanisms underlying these conditions are not necessarily equivalent. Consequently, interventions selected exclusively according to lesion morphology may fail to address the factors responsible for behavioral persistence. Conversely, premature attribution of unusual dermatological findings to psychiatric causes may delay the identification of an underlying medical disorder and undermine patient confidence. The central clinical challenge is therefore to integrate diagnostic reasoning across specialties without reducing either the dermatological or psychiatric dimensions of the problem. Existing classification proposals, clinical reviews, and treatment investigations provide a foundation for this approach, but their findings remain dispersed across different disciplines, highlighting the need for a synthesis that connects psychopathology, dermatological diagnosis, and interdisciplinary

DESARROLLO

Development

Psychopathological Mechanisms of Self-Inflicted Dermatoses

Self-inflicted dermatoses constitute a heterogeneous spectrum of conditions in which psychological disturbances and repetitive behaviors contribute to cutaneous injury. Excoriation disorder is particularly associated with difficulties in behavioral inhibition, emotional regulation, and the control of repetitive impulses. Although patients frequently recognize the consequences of skin manipulation, they may experience considerable difficulty interrupting the

behavior. The development and persistence of these manifestations involve interactions between psychological vulnerability, environmental stimuli, and reinforcement mechanisms that maintain repetitive skin damage (Torales et al., 2020).

Emotional distress represents an important factor in the clinical expression of excoriation disorder. Anxiety, frustration, boredom, and psychological tension may precede episodes of skin manipulation, while temporary relief following the behavior can reinforce its recurrence. However, this relationship is not universal, since some patients exhibit automatic picking without clearly identifiable emotional triggers. Calikuşu et al. (2003) identified significant associations between psychogenic excoriations and psychiatric disorders, whereas Grant and Chamberlain (2017) demonstrated relationships between symptom severity, impulsivity, anxiety, and depressive manifestations. These findings suggest that psychopathological assessment should distinguish between emotional triggers, habitual behavioral patterns, and associated psychiatric conditions.

Clinical Manifestations and Dermatological Diagnosis

The dermatological manifestations of self-inflicted lesions vary according to the frequency, intensity, duration, and mechanism of injury. Common findings include superficial excoriations, erosions, hemorrhagic crusts, post-inflammatory hyperpigmentation, and residual scars. Lesions frequently occur in accessible anatomical regions, particularly the face and extremities, although their distribution may differ according to individual behavioral patterns. Recurrent manipulation can compromise the epidermal barrier, increase susceptibility to secondary infections, and interfere with normal tissue repair (Misery et al., 2012; Jafferany et al., 2020).

Accurate diagnosis requires differentiating excoriation disorder from dermatitis artefacta and other dermatological or psychiatric conditions. Excoriation disorder involves recurrent skin picking accompanied by unsuccessful attempts to discontinue the behavior, whereas dermatitis artefacta is characterized by self-produced lesions within a factitious presentation, often associated with limited disclosure of the mechanism responsible for injury. Gieler et al. (2013) emphasized the importance of distinguishing these entities through behavioral characteristics, psychological context, and clinical presentation.

The differential diagnosis should also consider pruritic dermatoses, acne, inflammatory skin diseases, neuropathic conditions, and other disorders capable of producing excoriated lesions. Dermatological examination, detailed medical history, and selected complementary investigations are necessary when the clinical findings suggest an alternative organic explanation. Unusual lesion morphology may raise diagnostic suspicion but should never independently establish a psychiatric diagnosis (Lavery et al., 2018; Torales et al., 2023).

Psychiatric Comorbidities and Psychosocial Consequences

Psychiatric comorbidities contribute substantially to the clinical complexity of self-inflicted dermatoses. Anxiety disorders, depressive symptoms, obsessive-compulsive manifestations, and difficulties with impulse control may coexist with pathological skin picking. These associations can influence symptom persistence, treatment adherence, and the patient's capacity to regulate repetitive behaviors. Nevertheless, the presence of psychiatric comorbidity does not necessarily establish a causal relationship, since psychological symptoms may precede or develop as a consequence of chronic dermatological injury (Grant & Chamberlain, 2017).

The psychosocial consequences extend beyond the physical severity of the lesions. Patients may experience embarrassment, social avoidance, reduced self-esteem, and functional limitations associated with visible skin damage. These difficulties can create a reinforcing relationship between emotional distress and repetitive manipulation, contributing to disease persistence. Epidemiological findings further support the clinical significance of this condition. Farhat et al. (2023), in a meta-analysis involving 38,038 participants across 19 studies, estimated a pooled prevalence of 3.45%, demonstrating that excoriation disorder represents a meaningful concern for mental health and dermatological services.

Evidence-Based Psychological and Pharmacological Treatment

Behavioral interventions constitute an important component of treatment for excoriation disorder. Habit reversal training focuses on identifying triggering situations, increasing awareness of repetitive behaviors, and introducing

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alternative responses incompatible with skin picking. Cognitive behavioral approaches may additionally address maladaptive beliefs, emotional triggers, and difficulties with self-regulation. Teng et al. (2006) reported favorable findings using habit reversal techniques, while Schumer et al. (2016) identified evidence supporting behavioral treatment over inactive control conditions.

Pharmacological interventions have also been investigated, although their effectiveness varies across clinical studies. Grant et al. (2016), in a randomized trial involving 66 adults, evaluated N-acetylcysteine and reported clinical improvement in 47% of treatment completers receiving the intervention compared with 19% receiving placebo. Nevertheless, pharmacotherapy should be interpreted within the limitations of existing evidence, particularly regarding long-term outcomes and treatment response heterogeneity.

Recent developments include remotely delivered psychological interventions. Asplund et al. (2025) evaluated therapist-guided internet-based acceptance-enhanced behavior therapy and demonstrated greater symptom improvement than a waiting-list control condition. These findings suggest that digital interventions may expand treatment accessibility, although long-term effectiveness and generalizability require further investigation.

Interdisciplinary Clinical Management

The management of self-inflicted dermatoses requires coordination between dermatological, psychiatric, and psychological services. Dermatological treatment addresses tissue injury, infection prevention, wound care, and the identification of accompanying skin disorders. Psychiatric assessment contributes to diagnostic clarification and management of relevant mental health conditions, while psychological interventions target repetitive behavioral patterns, emotional regulation, and relapse prevention (Jafferany et al., 2020).

In dermatitis artefacta, the therapeutic relationship is particularly important because direct confrontation regarding the origin of lesions may compromise trust and continuity of care. Mohandas et al. (2013) emphasized the value of multidisciplinary psychodermatology services in managing complex presentations. Similarly, Gerlero et al. (2026), in a Brazilian retrospective investigation involving 42 patients, highlighted the importance of clinical communication, individualized management, and therapeutic engagement.

Although interdisciplinary approaches offer a coherent framework for treatment, controlled comparative evidence remains limited. Therefore, their clinical value should be evaluated through measures incorporating dermatological improvement, psychiatric symptom control, functional recovery, treatment adherence, and recurrence.

International Evidence and Latin American Perspectives

Research on self-inflicted dermatoses has expanded internationally, contributing to greater understanding of diagnostic classification, psychopathological characteristics, and therapeutic alternatives. However, differences in healthcare infrastructure, specialized mental health accessibility, and cultural attitudes toward psychiatric disorders may influence recognition and management.

Latin American contributions have strengthened the international evidence base. Torales et al. (2020), through collaborative research involving Paraguay and Brazil, examined the clinical and psychological dimensions of excoriation disorder. Furthermore, the Brazilian investigation by Gerlero et al. (2026) provided regional clinical evidence concerning dermatitis artefacta and the difficulties associated with sustained therapeutic management.

Despite these contributions, additional studies are required to clarify regional epidemiological patterns, identify barriers to specialized care, and evaluate the applicability of interdisciplinary interventions in diverse healthcare environments. Strengthening collaboration between dermatology, psychiatry, and psychology may contribute to more consistent diagnostic assessment and improved continuity of care.

Overall, the available evidence supports understanding self-inflicted dermatoses as multifactorial conditions in which dermatological injury, psychological processes, and psychiatric manifestations interact. Their clinical management therefore requires accurate diagnostic differentiation, individualized therapeutic strategies, and coordinated attention to both physical and psychological outcomes.

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OBJETIVO GENERAL Y OBJETIVOS ESPECÍFICOS

General Objective

General Objective

To critically analyze the psychopathological mechanisms, dermatological manifestations, diagnostic characteristics, and interdisciplinary therapeutic approaches associated with self-inflicted dermatoses and excoriation disorder through a comprehensive review of international scientific literature, incorporating Latin American contributions to identify evidence-based clinical recommendations and opportunities for improving integrated patient care.

Specific Objectives

Cognitive Domain: Knowledge, Analysis, and Evaluation

1. **Identify and classify** the principal forms of self-inflicted dermatoses, emphasizing the clinical and psychopathological differences between excoriation disorder, dermatitis artefacta, and other conditions associated with repetitive cutaneous injury.
2. **Analyze and differentiate** the psychological and psychiatric mechanisms contributing to skin manipulation, including emotional dysregulation, anxiety, compulsivity, impulsivity, and behavioral reinforcement, considering their relationship with clinical manifestations and disease persistence.
3. **Evaluate and compare** the available scientific evidence regarding psychological, pharmacological, and interdisciplinary interventions, identifying their therapeutic effectiveness, methodological limitations, and applicability across different healthcare settings.

Psychomotor Domain: Clinical and Procedural Competencies

4. **Examine and organize** the clinical procedures involved in dermatological assessment, including lesion characterization, anatomical distribution, recognition of complications, and selection of complementary diagnostic investigations, to establish a structured framework for differential diagnosis.
5. **Develop a proposed clinical assessment framework** integrating dermatological examination, psychiatric screening, behavioral evaluation, and interdisciplinary referral criteria, with the purpose of supporting systematic clinical decision-making. This framework will be derived from the reviewed literature rather than from direct patient interventions.

Affective Domain: Professional Attitudes and Patient-Centered Care

6. **Assess and promote** the importance of empathy, confidentiality, nonjudgmental communication, and therapeutic trust in the management of patients with self-inflicted dermatoses, recognizing the influence of stigma and psychological distress on treatment adherence.
7. **Integrate and justify** the principles of interdisciplinary collaboration, ethical responsibility, and culturally sensitive care, emphasizing the contribution of dermatology, psychiatry, and psychology to comprehensive clinical management and the relevance of international and Latin American perspectives.

Together, these objectives provide a structured foundation for examining self-inflicted dermatoses from complementary scientific and clinical perspectives. Their organization incorporates the progressive cognitive processes of Bloom's taxonomy, while addressing procedural competencies and professional attitudes relevant to healthcare practice. Because the present study is a literature review, the psychomotor and affective objectives are approached through the analysis and formulation of clinical recommendations rather than through direct measurement of practical skills or behavioral changes in patients or healthcare professionals.

OBJETO DE ESTUDIO

The object of study of this review comprises self-inflicted dermatoses, with particular emphasis on excoriation disorder and dermatitis artefacta, understood as clinical conditions characterized by cutaneous injuries associated with psychological, behavioral, and psychiatric mechanisms. The investigation focuses on the relationship between psychopathological factors, dermatological manifestations, diagnostic complexity, and interdisciplinary therapeutic interventions, considering their influence on disease persistence, clinical outcomes, and patients' psychosocial well-being (Gieler et al., 2013; Torales et al., 2020).

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The population of interest includes adolescents and adults affected by recurrent self-inflicted skin lesions, particularly individuals presenting with compulsive or repetitive skin manipulation, emotional dysregulation, psychiatric comorbidities, or factitious dermatological manifestations. The review also considers clinical evidence generated by dermatologists, psychiatrists, and psychologists involved in the assessment and management of these conditions. Because this investigation is based on previously published scientific literature, the units of analysis are research articles, clinical studies, systematic reviews, and other relevant scientific publications rather than patients directly recruited or evaluated by the authors.

The phenomenon under investigation is examined through four interconnected dimensions. The **psychopathological dimension** addresses anxiety, depressive symptoms, compulsivity, impulsivity, emotional regulation, and behavioral reinforcement mechanisms associated with repetitive skin injury. The **dermatological dimension** considers lesion morphology, anatomical distribution, complications, diagnostic criteria, and differentiation from organic skin diseases. The **therapeutic dimension** evaluates psychological interventions, pharmacological alternatives, dermatological management, and coordinated interdisciplinary care. Finally, the **psychosocial dimension** incorporates functional impairment, stigma, therapeutic adherence, and quality-of-life consequences (Grant & Chamberlain, 2017; Lochner et al., 2017; Jafferany et al., 2020).

The geographical scope is international, incorporating research from North America, Europe, and other regions, with particular attention to Latin American scientific contributions. Studies involving investigators and clinical populations from Paraguay and Brazil provide relevant perspectives regarding psychopathological characteristics, diagnostic practices, and treatment challenges within different healthcare environments (Torales et al., 2020; Gerlero et al., 2026). This approach facilitates the comparison of scientific findings while recognizing potential differences in healthcare accessibility, specialized services, and clinical resources.

The investigation is limited to the clinical and scientific analysis of self-inflicted dermatological conditions and their relationship with psychiatric and psychological processes. It does not involve experimental interventions, direct patient recruitment, or the collection of primary clinical data. Other forms of intentional self-injury, including suicidal behavior, are considered only when necessary for differential diagnosis and are not treated as equivalent to excoriation disorder or dermatitis artefacta.

Accordingly, the central object of study is the interaction between behavioral and psychiatric mechanisms and recurrent self-inflicted skin damage, with the purpose of identifying diagnostic distinctions, evaluating therapeutic evidence, and establishing a scientific foundation for comprehensive interdisciplinary management.

METODOLOGÍA

Study Design

This study was structured as a descriptive and analytical narrative literature review based on the scientific method and a qualitative synthesis of published biomedical evidence. The methodological approach was selected to examine the immunopathogenesis, clinical recognition, diagnostic evaluation, and therapeutic management of drug reaction with eosinophilia and systemic symptoms (DRESS) and Stevens–Johnson syndrome/toxic epidermal necrolysis (SJS/TEN). Unlike experimental investigations, this review does not involve direct patient participation or clinical interventions. Its purpose is to integrate existing scientific knowledge, compare relevant findings, and identify areas requiring further investigation.

FASES DEL DESARROLLO

Phase I. Identification and Delimitation of the Research Problem

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The initial phase focused on defining the clinical and scientific problems associated with excoriation disorder and dermatitis artefacta. Particular attention was directed toward diagnostic difficulties, psychiatric comorbidities, recurrent cutaneous injury, and limitations in therapeutic coordination.

The research problem was delimited to the interaction between psychological mechanisms and dermatological manifestations, considering the potential consequences of fragmented clinical assessment. Previous investigations have emphasized the importance of accurate classification and multidisciplinary management, providing the conceptual foundation for this review (Gieler et al., 2013; Torales et al., 2020).

Phase II. Formulation of Research Questions and Analytical Assumptions

The second phase established the questions guiding the review. These addressed the psychopathological mechanisms contributing to repetitive skin manipulation, the clinical characteristics distinguishing excoriation disorder from other self-inflicted dermatoses, and the therapeutic approaches supported by available scientific evidence.

The principal analytical assumption was that an integrated assessment of behavioral, psychiatric, and dermatological factors provides a more comprehensive basis for clinical decision-making than isolated evaluation of cutaneous lesions. This assumption was treated as a framework for critical examination rather than as an experimentally tested hypothesis.

Phase III. Identification and Selection of Scientific Literature

The third phase addressed the identification of relevant scientific publications. A preliminary bibliographic corpus of 20 references was established, including clinical studies, randomized trials, observational investigations, and reviews addressing the principal dimensions of the research problem.

The search framework identified PubMed/MEDLINE and Scopus as the principal databases, using combinations of terms such as *excoriation disorder*, *skin-picking disorder*, *psychogenic excoriation*, *dermatitis artefacta*, *psychopathology*, *diagnosis*, and *interdisciplinary treatment*. The proposed period covered publications from January 2000 through October 2026, including English, Spanish, and Portuguese literature.

For reproducibility, database-specific searches should preserve the search strings, execution dates, retrieved records, and duplicate-removal decisions. Publications would be assessed according to their relevance to the research objectives, methodological characteristics, and contribution to the clinical understanding of self-inflicted dermatoses. The preliminary bibliography was not treated as an exhaustive systematic sample.

Phase IV. Organization and Extraction of Information

The fourth phase involved establishing a standardized framework for organizing the scientific information. Publications were classified according to their principal contributions to psychopathology, dermatological diagnosis, psychiatric comorbidities, therapeutic interventions, and interdisciplinary management.

The extraction framework included publication characteristics, study design, population, clinical findings, diagnostic methods, therapeutic approaches, and reported outcomes. Particular attention was directed toward distinguishing evidence derived from randomized clinical trials from observational findings and expert clinical interpretations.

This organization was intended to facilitate comparison between investigations and identify areas of agreement, uncertainty, and methodological limitation.

Phase V. Critical Evaluation and Comparative Analysis

The fifth phase focused on the critical interpretation of scientific evidence. Investigations were considered in relation to their methodological design, sample characteristics, diagnostic definitions, outcome measurements, and relevance to the research questions.

For example, studies examining behavioral therapies were distinguished from pharmacological trials, while research concerning dermatitis artefacta was analyzed separately when its diagnostic characteristics differed from those of excoriation disorder. Evidence from controlled studies was considered particularly relevant when evaluating

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therapeutic effectiveness, whereas observational investigations contributed information about clinical presentation, comorbidities, and real-world management (Schumer et al., 2016; Grant et al., 2016).

Conflicting findings and limitations were incorporated into the interpretation rather than treated as equivalent evidence of effectiveness.

Phase VI. Thematic Integration and Interdisciplinary Synthesis

The sixth phase organized the reviewed evidence into interconnected thematic categories: psychopathological mechanisms, dermatological manifestations, differential diagnosis, psychiatric and psychosocial consequences, and therapeutic management.

The synthesis emphasized relationships between behavioral triggers, recurrent tissue injury, emotional distress, and treatment response. Scientific contributions from dermatology, psychiatry, and psychology were integrated to construct a multidimensional interpretation of these conditions.

International investigations were considered alongside Latin American contributions to identify areas of clinical convergence and potential differences in healthcare accessibility and specialized treatment resources. Particular relevance was assigned to research involving Paraguay and Brazil, which contributes regional perspectives to international psychodermatological literature (Torales et al., 2020; Gerlero et al., 2026).

Phase VII. Interpretation and Formulation of Clinical Implications

The final phase focused on translating the thematic synthesis into clinically relevant conclusions while respecting the limitations of the available evidence. Particular attention was directed toward early recognition, accurate differential diagnosis, appropriate psychiatric assessment, individualized psychological interventions, and coordinated dermatological treatment.

The interpretation also considered the need for further investigations involving standardized diagnostic criteria, longer therapeutic follow-up, and greater geographical diversity.

Rather than establishing universal treatment protocols, this phase aimed to identify evidence-supported considerations for interdisciplinary management and priorities for future research. The resulting framework emphasizes diagnostic precision, patient-centered communication, and coordinated clinical care as essential components in the management of self-inflicted dermatoses.

RESULTADOS Y DISCUSIÓN

Figure 1.

Prevalence Estimates of Excoriation Disorder Across Epidemiological Studies.

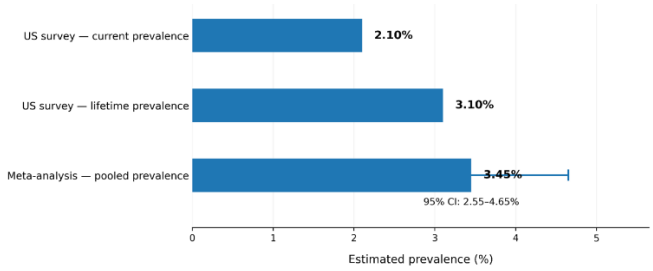


Figure 1 presents the prevalence estimates of excoriation disorder reported in two major epidemiological investigations, distinguishing between current prevalence, lifetime prevalence, and pooled prevalence obtained through meta-analysis. The findings demonstrate variations in the frequency of the disorder according to the observation period, study population, and methodological approach used to identify affected individuals. The three estimates range from

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2.10% to 3.45%, providing quantitative information on the epidemiological distribution of excoriation disorder across the populations evaluated (Grant & Chamberlain, 2020; Farhat et al., 2023).

Grant and Chamberlain (2020) investigated the occurrence of excoriation disorder in a sample of 10,169 adults aged 18–69 years in the United States. Their results identified 213 individuals reporting current excoriation disorder, corresponding to a prevalence of 2.10%. Additionally, 318 participants reported experiencing the disorder at some point during their lives, representing a lifetime prevalence of 3.10%. The difference of 1.00 percentage point between these estimates reflects the distinction between individuals reporting active symptoms and those reporting either current or previous manifestations. Both measurements originated from the same study population, allowing the comparison of two different temporal definitions of prevalence within a single epidemiological investigation.

The highest point estimate illustrated in Figure 1 corresponds to the systematic review and meta-analysis conducted by Farhat et al. (2023), which incorporated 19 studies involving 38,038 participants. This investigation reported a pooled prevalence of 3.45%, with a 95% confidence interval ranging from 2.55% to 4.65%. The confidence interval is represented by the horizontal error bar accompanying the pooled estimate, indicating the statistical uncertainty associated with the combined result. The pooled prevalence was 1.35 percentage points higher than the current prevalence reported by Grant and Chamberlain (2020), although these estimates were obtained through different analytical approaches and should not be interpreted as evidence of a temporal increase in the occurrence of the disorder.

The variation between the estimates is accompanied by important differences in study characteristics. Grant and Chamberlain (2020) obtained prevalence information through a survey involving adults from the United States, whereas Farhat et al. (2023) combined findings from multiple investigations with differences in participant recruitment, population characteristics, and diagnostic assessment. The meta-analysis included studies employing different approaches to identifying excoriation disorder, ranging from diagnostic criteria to self-reported symptoms or diagnoses. Consequently, the pooled estimate represents a synthesis of heterogeneous epidemiological information rather than a direct measurement from a single population.

The results also distinguish between the precision and interpretative scope of individual survey estimates and combined epidemiological findings. The 95% confidence interval presented for the meta-analysis provides a measure of uncertainty surrounding its pooled estimate; equivalent confidence intervals are not displayed for the individual survey estimates in Figure 1. Therefore, the graphical differences should be regarded as descriptive comparisons rather than statistically established differences between populations. Moreover, because a primary investigation may contribute to the evidence synthesized in a meta-analysis, the estimates should not automatically be considered statistically independent.

Finally, the findings presented in Figure 1 specifically concern excoriation disorder and should not be generalized to all forms of self-inflicted dermatoses. Dermatitis artefacta and other self-produced dermatological conditions differ in their diagnostic characteristics and were not collectively represented by these prevalence estimates. Overall, the graphical representation summarizes the principal epidemiological measurements identified in the selected literature, documenting the occurrence of excoriation disorder across distinct methodological frameworks and establishing a quantitative reference for the subsequent analysis of its clinical and psychopathological characteristics (Grant &

Figure 2.

Comparative Clinical Characteristics of Excoriation Disorder and Dermatitis Artifact.

CLINICAL DOMAIN	EXCORIATION DISORDER	DERMATITIS ARTEFACTA
Dominant pattern	Recurrent picking or scratching that produces cutaneous injury	Self-produced lesions occurring in a factitious presentation
Behavioral disclosure	Picking is often recognized; repeated attempts to stop	Production of lesions may not be disclosed or fully acknowledged
Lesion appearance	Excoriations, erosions, crusts, pigment changes and scars	Variable or atypical lesions; angular or sharply bordered forms may raise suspicion
Typical context	Urges, emotional triggers or automatic repetitive behavior	Complex psychological context; not defined by a picking-relief cycle
Diagnostic emphasis	Recurrent picking, unsuccessful control attempts and impairment; exclude other causes	Careful dermatologic exclusion, clinical chronology and supportive psychological assessment
Management focus	Behavioral therapy, skin care and psychiatric support as needed	Nonconfrontational relationship, skin care and coordinated psychodermatologic follow-up

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Figure 2 presents a comparative analysis of the principal clinical and psychopathological characteristics of excoriation disorder and dermatitis artefacta, organized into six diagnostic and therapeutic domains. The findings illustrate differences in behavioral patterns, recognition of self-inflicted injury, lesion morphology, psychological context, diagnostic assessment, and clinical management. Although both conditions involve cutaneous damage resulting from patient-related behaviors, the reviewed literature identifies distinct characteristics that contribute to their differentiation within the broader classification of self-inflicted dermatoses (Gieler et al., 2013; Lavery et al., 2018; Torales et al., 2020).

The first comparative domain concerns the behavioral mechanisms responsible for cutaneous injury. Excoriation disorder is characterized by recurrent skin picking, scratching, or manipulation that produces visible lesions and is accompanied by repeated unsuccessful attempts to control the behavior. Patients may recognize the repetitive nature of their actions while experiencing considerable difficulty interrupting them. In contrast, dermatitis artefacta involves self-produced lesions within a factitious clinical presentation, frequently accompanied by psychological circumstances that complicate the identification of the mechanism responsible for injury. These differences distinguish repetitive behavioral dysregulation from the clinical manifestations associated with factitious dermatological disorders, although individual presentations may overlap (Gieler et al., 2013; Torales et al., 2023).

Regarding behavioral awareness and disclosure, the reviewed studies describe differences between the two conditions. Patients with excoriation disorder generally recognize episodes of skin manipulation, although awareness may vary according to whether the behavior occurs automatically or in response to identifiable emotional triggers. Repeated attempts to reduce or discontinue picking constitute a relevant diagnostic characteristic. Conversely, individuals presenting with dermatitis artefacta may not disclose their contribution to lesion development, and recognition of the underlying behavior may be complicated by psychological factors or difficulties discussing the condition. Lavery et al. (2018) identified limited acknowledgment of lesion production as an important challenge in clinical assessment, whereas Torales et al. (2020) emphasized the difficulties experienced by patients with excoriation disorder when attempting to control recurrent picking.

The dermatological findings demonstrate both similarities and differences in lesion presentation. Excoriation disorder commonly produces erosions, excoriations, hemorrhagic crusts, pigmentation changes, and scars associated with repeated manipulation. These manifestations may occur in different stages of healing and frequently affect anatomically accessible regions. Dermatitis artefacta, however, may exhibit more variable or atypical morphological characteristics, including sharply defined lesions, unusual configurations, or patterns that do not correspond to the expected evolution of conventional dermatological conditions. Nevertheless, neither lesion morphology nor anatomical distribution is independently sufficient to establish a definitive diagnosis. The reviewed classification proposals emphasize the importance of integrating dermatological findings with behavioral history and psychiatric evaluation (Gieler et al., 2013; Lavery et al., 2018).

Differences were also identified in the psychological circumstances associated with lesion development. Excoriation disorder may involve emotional tension, anxiety, repetitive urges, or automatic behavioral sequences. Temporary relief following skin manipulation has been described in some patients, although this pattern is not universally present. In

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dermatitis artefacta, the psychological context is more closely associated with the complexity of factitious presentations and cannot be adequately characterized through the same repetitive picking-and-relief mechanism. These distinctions are reflected in the diagnostic approaches described in the literature, which emphasize identifying the psychological function and circumstances of cutaneous injury rather than relying exclusively on its physical consequences (Mohandas et al., 2013; Torales et al., 2020).

The fifth domain addresses diagnostic assessment. For excoriation disorder, the clinical evaluation focuses on recurrent skin picking, repeated unsuccessful attempts to control the behavior, clinically significant distress or functional impairment, and exclusion of alternative medical or psychiatric explanations. In dermatitis artefacta, the diagnostic process places greater emphasis on inconsistencies between lesion presentation and recognized dermatological disorders, chronological characteristics, and careful assessment of the clinical and psychological context. In both conditions, differential diagnosis requires consideration of organic skin diseases, psychiatric comorbidities, and other causes of repetitive or intentional skin injury. The reviewed evidence consistently indicates that comprehensive clinical assessment is necessary to distinguish these entities and avoid inappropriate diagnostic attribution (Gieler et al., 2013; Torales et al., 2023).

Finally, the comparison identifies different therapeutic priorities. Excoriation disorder is commonly managed through behavioral interventions, including habit reversal techniques and cognitive behavioral approaches, combined with dermatological treatment and psychiatric support when indicated. In dermatitis artefacta, clinical management places particular emphasis on establishing a stable therapeutic relationship, avoiding confrontational communication, providing appropriate wound care, and facilitating coordinated psychodermatological follow-up. Mohandas et al. (2013) described the importance of multidisciplinary clinical services in managing dermatitis artefacta, while Lochner et al. (2017) summarized the evidence supporting behavioral and pharmacological interventions for excoriation disorder.

Figure 3.

Therapeutic Outcomes and Evidence for Behavioral and Pharmacological Interventions.

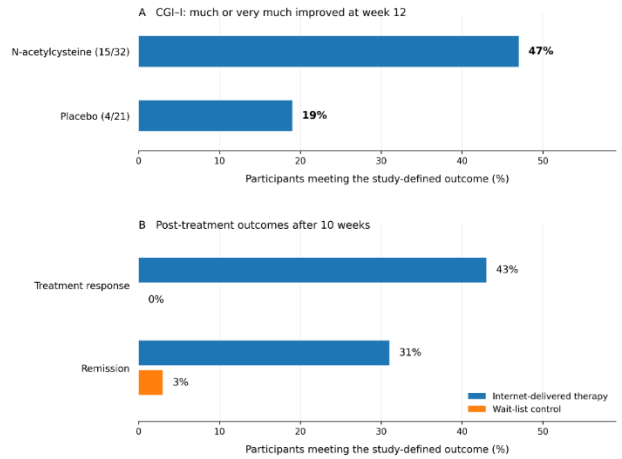


Figure 3 presents the therapeutic outcomes reported in two randomized clinical trials evaluating pharmacological and psychological interventions for excoriation disorder. The graphical representation is divided into two analytical panels, illustrating clinical improvement following N-acetylcysteine treatment and therapeutic response following internet-delivered acceptance-enhanced behavior therapy. Both investigations identified differences between active intervention groups and their respective control conditions, although treatment duration, outcome definitions, and assessment instruments differed between studies (Grant et al., 2016; Asplund et al., 2025).

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The first panel summarizes the randomized, double-blind clinical trial conducted by Grant et al. (2016), which investigated the effectiveness of N-acetylcysteine in 66 adults diagnosed with excoriation disorder. Participants received N-acetylcysteine or placebo for 12 weeks, and therapeutic outcomes were evaluated using standardized measures of symptom severity and clinical improvement. Among the 53 participants who completed the investigation, 47% of those receiving N-acetylcysteine, corresponding to 15 of 32 individuals, were classified as much or very much improved according to the Clinical Global Impression–Improvement scale. In comparison, 19% of placebo recipients, corresponding to 4 of 21 participants, achieved the same classification. This represented an absolute difference of approximately 28 percentage points between treatment groups, with a statistically significant result ($p = .03$).

The investigation additionally documented changes in symptom severity using the modified Yale-Brown Obsessive Compulsive Scale for neurotic excoriation. Mean scores decreased from 18.9 to 11.5 in the N-acetylcysteine group and from 17.9 to 14.1 in the placebo group over the 12-week observation period. The treatment-by-time comparison demonstrated a statistically significant difference ($p = .048$). However, improvements in psychiatric symptom measurements were not accompanied by statistically significant between-group differences in psychosocial functioning. Therefore, the trial documented favorable changes in skin-picking symptoms while identifying differences between symptomatic improvement and broader functional outcomes (Grant et al., 2016).

The second panel illustrates findings from the randomized controlled trial conducted by Asplund et al. (2025), which evaluated therapist-guided internet-delivered acceptance-enhanced behavior therapy. The investigation included 70 participants, equally allocated to a 10-week psychological intervention or a waiting-list control condition. Symptom severity was primarily assessed using the Skin Picking Scale–Revised, allowing the researchers to quantify changes in repetitive skin manipulation following treatment.

At the end of the intervention period, 43% of participants receiving internet-delivered behavioral therapy met the study criteria for treatment response, compared with 0% of participants assigned to the waiting-list condition. Similarly, remission was reported in 31% of participants receiving the intervention and 3% of controls. These findings corresponded to absolute between-group differences of 43 and 28 percentage points for treatment response and remission, respectively. Response and remission represented separate clinical outcome classifications and therefore should not be interpreted as mutually exclusive categories or combined into a single percentage (Asplund et al., 2025).

Further statistical analysis identified a significant between-group difference of −5.1 points on the Skin Picking Scale–Revised at post-treatment assessment ($p < .001$). The standardized between-group effect size was reported as Cohen's $d = 1.30$, with a 95% confidence interval of 0.92–1.69. At the six-month follow-up, the investigators observed an increase in symptom severity relative to the immediate post-treatment assessment, although improvement from baseline remained statistically significant. These findings provide information about both the initial therapeutic response and the subsequent course of symptoms following the completion of structured psychological intervention (Asplund et al., 2025).

Additional evidence concerning behavioral interventions was identified in the systematic review and meta-analysis conducted by Schumer et al. (2016). The analysis of three randomized controlled trials demonstrated a statistically significant advantage of behavioral treatments over inactive control conditions, with a standardized mean difference of 0.69 and a 95% confidence interval of 0.32–1.05 ($p < .001$). Earlier randomized evidence from Teng et al. (2006) also documented greater reductions in skin-picking behavior following habit reversal training compared with a waiting-list control condition. These investigations evaluated therapeutic outcomes using different assessment instruments, but collectively documented improvements in repetitive skin-picking symptoms following structured behavioral interventions.

The results presented in Figure 3 also demonstrate methodological differences between the pharmacological and psychological trials. Grant et al. (2016) evaluated global clinical improvement among participants who completed treatment, whereas Asplund et al. (2025) reported response and remission according to criteria established for their behavioral intervention. Furthermore, the pharmacological investigation employed a placebo-controlled design, while the psychological intervention was compared with a waiting-list condition. Consequently, the percentages represented in the two panels cannot be used to establish the comparative superiority of N-acetylcysteine over behavioral therapy, or vice versa.

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Figure 4.

Integrated Dermatological, Psychiatric, and Psychological Management Framework



Figure 4 illustrates an integrated clinical management framework derived from the scientific literature concerning excoriation disorder and other self-inflicted dermatoses. The proposed structure organizes clinical assessment, diagnostic formulation, therapeutic interventions, and longitudinal follow-up into interconnected components involving dermatology, psychiatry, and psychology. The reviewed evidence identifies complementary responsibilities across these specialties, particularly in the differentiation of recurrent self-inflicted skin injuries and the management of associated psychopathological manifestations (Mohandas et al., 2013; Jafferany et al., 2020; Torales et al., 2023).

The initial component addresses the clinical presentation of patients with recurrent excoriations, unexplained cutaneous lesions, or persistent skin damage. Such manifestations may result from repetitive picking behaviors, factitious injury, underlying organic dermatological disorders, or combinations of these conditions. The literature emphasizes that lesion appearance alone is insufficient to determine the underlying psychopathological mechanism. Consequently, the framework incorporates three parallel assessment domains intended to characterize the dermatological, psychiatric, and behavioral dimensions of the clinical presentation (Gieler et al., 2013; Lavery et al., 2018).

The dermatological domain includes systematic characterization of lesion morphology, anatomical distribution, duration, healing patterns, and possible complications. Clinical evaluation also involves identifying coexisting inflammatory, infectious, or pruritic skin conditions that may explain or contribute to recurrent injury. The assessment of epidermal disruption, secondary infection, scarring, and wound evolution constitutes an important component of dermatological care. Mohandas et al. (2013) identified dermatological evaluation as an essential element of multidisciplinary management, particularly for distinguishing dermatitis artefacta from organic cutaneous disease.

The psychiatric domain incorporates assessment of associated mental health conditions, including anxiety, depressive symptoms, obsessive-compulsive manifestations, and other clinically relevant disturbances. Psychiatric evaluation also contributes to differentiating excoriation disorder from factitious presentations and other forms of self-injurious behavior. The reviewed literature describes psychiatric comorbidities as frequent clinical findings in patients with psychodermatological conditions, although their presence and severity vary across individuals. Jafferany et al. (2020) emphasized the contribution of psychiatric collaboration to treatment selection and the management of accompanying psychological symptoms.

The psychological domain focuses on behavioral characteristics, emotional triggers, awareness of repetitive manipulation, and the functional consequences of the disorder. In excoriation disorder, assessment may identify automatic or emotionally triggered picking, difficulties controlling repetitive urges, and patterns of temporary relief

following skin manipulation. These characteristics provide information for behavioral formulation and the selection of appropriate psychological interventions. The available evidence identifies habit reversal training and cognitive behavioral approaches among the principal nonpharmacological treatment options for excoriation disorder (Lochner et al., 2017; Jafferany et al., 2020).

The three assessment domains converge in an integrated clinical formulation that distinguishes excoriation disorder, dermatitis artefacta, and organic or mixed dermatological presentations. This component represents the synthesis of clinical information rather than a diagnosis based on any single sign or symptom. The reviewed literature emphasizes the importance of considering behavioral awareness, lesion characteristics, psychiatric context, and the potential coexistence of organic disease. Torales et al. (2023) described the diagnostic complexity of dermatitis artefacta and the importance of a supportive, nonconfrontational clinical approach when evaluating patients with suspected factitious skin lesions.

The subsequent component organizes therapeutic management into three complementary areas: cutaneous care, behavioral intervention, and psychiatric support. Dermatological treatment addresses lesion healing, infection prevention, and accompanying skin disease. Psychological treatment targets repetitive behaviors, emotional triggers, and functional impairment, particularly through structured behavioral techniques when clinically indicated. Psychiatric management focuses on relevant comorbidities and the consideration of pharmacological treatment according to individual clinical characteristics. These interventions are presented as complementary components rather than as universally necessary treatments for every patient (Lochner et al., 2017; Jafferany et al., 2020).

Evidence supporting coordinated management was identified in the retrospective investigation conducted by Mohandas et al. (2013), which included 28 patients with dermatitis artefacta attending a specialized psychodermatology service. The investigators reported that 93% of patients were successfully managed, defined as resolution or remission of the condition at the time of assessment. Although this finding describes favorable outcomes in a multidisciplinary clinical setting, the observational design and absence of a randomized comparison limit conclusions regarding the independent effectiveness of the care model.

Additional regional evidence was provided by Gerlero et al. (2026), who examined 42 patients with dermatitis artefacta at a Brazilian university dermatology center. The investigators documented challenges involving psychiatric referral, patient engagement, and continuity of care, with follow-up periods varying considerably between individuals. Their findings emphasized the importance of the therapeutic relationship and the dermatologist's role in maintaining clinical contact when specialized psychiatric participation is difficult to achieve.

The final component of Figure 4 represents longitudinal follow-up through the assessment of lesion healing, frequency of skin manipulation, psychological distress, functional recovery, treatment adherence, and recurrence. These domains reflect the multidimensional nature of the conditions reviewed and provide a structure for monitoring clinical evolution

DISCUSIÓN

The findings of this narrative review demonstrate that self-inflicted dermatoses represent a heterogeneous group of clinical conditions in which psychopathological mechanisms, dermatological manifestations, and behavioral characteristics interact. The evidence presented across the four figures supports the importance of distinguishing excoriation disorder from dermatitis artefacta and other forms of self-inflicted skin injury. Although these conditions share certain physical manifestations, their diagnostic characteristics and therapeutic requirements differ considerably. This observation is consistent with the classification proposed by Gieler et al. (2013), who emphasized the importance of integrating psychiatric and dermatological criteria when evaluating self-inflicted lesions. Similarly, Torales et al. (2020) described excoriation disorder as a multifactorial condition whose clinical complexity extends beyond visible cutaneous damage.

The epidemiological findings presented in Figure 1 confirm that excoriation disorder constitutes a relevant clinical and public health concern. Grant and Chamberlain (2020) reported a current prevalence of 2.1% and a lifetime prevalence of 3.1% among adults in the United States, while Farhat et al. (2023) estimated a pooled prevalence of 3.45% through

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a systematic review and meta-analysis. Although these estimates are relatively consistent, methodological differences involving diagnostic definitions, recruitment procedures, and population characteristics limit their direct comparability. The higher pooled estimate should not be interpreted as evidence of increasing disease frequency, since both investigations employed different epidemiological approaches. Furthermore, the predominance of female participants identified in several studies suggests potential sex-related differences in the clinical distribution of excoriation disorder, although differences in symptom recognition, reporting, and healthcare-seeking behaviors may also influence observed patterns.

The psychopathological characteristics identified throughout the review support the involvement of emotional dysregulation, anxiety, compulsivity, and behavioral reinforcement in the persistence of pathological skin picking. Calikuşu et al. (2003) demonstrated associations between psychogenic excoriations and psychiatric disorders, while Grant and Chamberlain (2017) identified relationships between greater symptom severity and psychological distress. These findings are compatible with behavioral models in which repetitive skin manipulation temporarily modifies uncomfortable emotional states, reinforcing subsequent episodes. Nevertheless, automatic picking behaviors and differences in individual awareness indicate that emotional tension cannot explain every clinical presentation. The heterogeneity of these mechanisms reinforces the importance of individualized psychological assessment rather than assuming that all patients experience the same behavioral triggers or psychiatric comorbidities.

The comparison presented in Figure 2 highlights the diagnostic difficulties associated with differentiating excoriation disorder from dermatitis artefacta. Although both conditions produce self-inflicted cutaneous lesions, excoriation disorder is primarily characterized by recurrent picking and unsuccessful attempts to control the behavior, whereas dermatitis artefacta occurs within a factitious clinical context that may involve limited disclosure of lesion production. This distinction is consistent with the observations of Lavery et al. (2018) and Torales et al. (2023), who emphasized that unusual lesion morphology should be interpreted alongside psychological characteristics and clinical history. Importantly, recognizing a potential behavioral contribution must not replace the investigation of organic dermatological diseases. Premature psychiatric attribution may delay appropriate diagnosis, particularly when inflammatory, infectious, or pruritic conditions coexist with repetitive skin manipulation.

Regarding therapeutic outcomes, Figure 3 demonstrates that both behavioral and pharmacological interventions have produced clinically relevant improvements, although the strength of evidence differs between treatment modalities. Grant et al. (2016) reported greater clinical improvement with N-acetylcysteine than placebo, providing evidence supporting its potential therapeutic role in excoriation disorder. However, Schumer et al. (2016) identified more consistent controlled evidence for behavioral interventions than for pharmacological treatments overall. These findings suggest that results from individual medication trials should be interpreted cautiously, particularly when considering long-term effectiveness and the variability of treatment response. The evidence does not support assuming that pharmacological intervention alone can address the complete range of psychological and dermatological manifestations associated with these conditions.

Recent investigations have expanded the therapeutic possibilities through remotely delivered psychological interventions. Asplund et al. (2025) demonstrated significant reductions in skin-picking symptoms following internet-delivered acceptance-enhanced behavior therapy, with higher response and remission percentages than those observed in the waiting-list control group. These findings complement earlier research supporting habit reversal training and cognitive behavioral approaches (Teng et al., 2006; Lochner et al., 2017). Nevertheless, the recurrence of some symptoms during follow-up indicates that maintaining therapeutic improvements remains an important challenge. Additionally, differences in treatment duration, intervention components, and outcome measurements prevent direct comparisons of therapeutic superiority between behavioral and pharmacological studies. Future investigations should therefore incorporate standardized clinical outcomes and longer observation periods to assess sustained improvement and relapse prevention.

The interdisciplinary framework illustrated in Figure 4 reflects the importance of coordinating dermatological, psychiatric, and psychological interventions. Mohandas et al. (2013) reported favorable outcomes among patients with dermatitis artefacta treated in a specialized multidisciplinary service, supporting the clinical relevance of integrated management. However, the retrospective design and absence of a controlled comparison prevent definitive conclusions regarding the independent effectiveness of this model. Similarly, Gerlero et al. (2026), in a Brazilian study involving

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42 patients, identified difficulties related to psychiatric referral, patient engagement, and continuity of care. Their findings emphasize the importance of maintaining a supportive therapeutic relationship, particularly when specialized mental health services are not readily accessible. Together, these investigations support interdisciplinary collaboration as a reasonable clinical strategy, while demonstrating the need for stronger comparative evidence.

From an international perspective, the incorporation of Latin American research contributes to a more geographically diverse understanding of psychodermatological disorders. Collaborative investigations involving Paraguay and Brazil have examined excoriation disorder and dermatitis artefacta from psychiatric and dermatological perspectives (Torales et al., 2020; Gerlero et al., 2026). However, regional epidemiological information remains insufficient to establish comprehensive prevalence estimates or identify consistent differences in therapeutic outcomes. Variations in mental health resources, referral pathways, socioeconomic circumstances, and specialized clinical services may influence disease recognition and treatment continuity. Consequently, additional multicenter studies involving Latin American populations are necessary to evaluate the applicability of diagnostic and therapeutic approaches developed in other healthcare systems.

Several limitations of the present review must be acknowledged. Its narrative design and selected bibliographic corpus do not provide the exhaustive evidence identification or formal risk-of-bias assessment characteristic of a systematic review. Furthermore, the included publications differ in diagnostic criteria, sample sizes, populations, therapeutic interventions, and outcome measurements, restricting quantitative comparisons. The prevalence estimates and therapeutic percentages presented in the figures originate from previously published investigations and do not represent newly collected clinical data. Additionally, the proposed interdisciplinary framework constitutes a conceptual synthesis rather than an independently validated clinical algorithm. These limitations should be considered when interpreting the findings and applying them to different patient populations.

Future research should prioritize standardized diagnostic assessment, prospective multicenter investigations, and randomized studies comparing psychological, pharmacological, and combined treatment strategies. Particular attention should be directed toward long-term recurrence, quality of life, psychiatric comorbidities, and the effectiveness of interdisciplinary care in resource-limited settings. Greater inclusion of Latin American populations would also contribute to evaluating cultural and healthcare-related factors that may affect clinical outcomes. Overall, the available evidence indicates that accurate diagnostic differentiation, individualized psychological intervention, appropriate dermatological treatment, and coordinated psychiatric support are central considerations in the comprehensive management of self-inflicted dermatoses. However, the comparative effectiveness and optimal organization of these interventions require further investigation.

CONCLUSIÓN

Self-inflicted dermatoses, particularly excoriation disorder and dermatitis artefacta, represent complex clinical conditions arising from the interaction of dermatological, psychological, and psychiatric factors. The findings of this narrative review demonstrate that recurrent cutaneous injury cannot be adequately understood through its physical manifestations alone, as emotional dysregulation, compulsive behaviors, psychiatric comorbidities, and individual psychological characteristics contribute to the development and persistence of these conditions. The available epidemiological evidence also confirms the clinical relevance of excoriation disorder, emphasizing the importance of improving its recognition and diagnostic assessment across healthcare settings (Grant & Chamberlain, 2020; Farhat et al., 2023).

Accurate differentiation between excoriation disorder and dermatitis artefacta constitutes a fundamental component of clinical management. Although both conditions may produce similar cutaneous lesions, their behavioral characteristics, psychological mechanisms, and diagnostic considerations differ substantially. Comprehensive dermatological examination, evaluation of psychiatric comorbidities, and individualized psychological assessment are therefore essential to reduce diagnostic uncertainty and distinguish these conditions from organic dermatological diseases. Maintaining a supportive, nonjudgmental therapeutic relationship is equally important, particularly when

limited disclosure, psychological distress, or difficulties with treatment adherence complicate clinical assessment (Gieler et al., 2013; Torales et al., 2023).

Regarding treatment, the reviewed evidence identifies behavioral interventions, especially habit reversal training and cognitive behavioral approaches, as relevant therapeutic options for excoriation disorder. Pharmacological interventions, including N-acetylcysteine, have demonstrated favorable outcomes in selected controlled investigations, although additional research is required to establish long-term effectiveness and optimal treatment selection. The integration of dermatological care, psychiatric support, and psychological intervention provides a comprehensive framework for addressing both tissue injury and the mechanisms associated with recurrent skin manipulation (Schumer et al., 2016; Grant et al., 2016; Jafferany et al., 2020).

International investigations, including contributions from Paraguay and Brazil, have expanded scientific understanding of these disorders. Nevertheless, important limitations remain concerning geographical representation, standardized diagnostic criteria, long-term therapeutic outcomes, and access to specialized psychodermatological services. Future research should prioritize multicenter investigations, prospective follow-up, and controlled evaluations of interdisciplinary care, particularly within Latin American healthcare systems.

In conclusion, the objectives of this review were addressed through the critical examination of psychopathological mechanisms, dermatological diagnostic characteristics, and available therapeutic evidence. The findings support an integrated, individualized, and patient-centered approach to self-inflicted dermatoses, while recognizing that the comparative effectiveness of different interdisciplinary management strategies has not been definitively established. Strengthening collaboration between dermatology, psychiatry, and psychology, together with improving diagnostic precision and access to evidence-based interventions, represents an important direction for advancing clinical management and promoting better long-term outcomes.

REFERENCIAS

- Arnold, L. M., Auchenbach, M. B., & McElroy, S. L. (2001). Psychogenic excoriation: Clinical features, proposed diagnostic criteria, epidemiology and approaches to treatment. *CNS Drugs, 15*(5), 351–359. doi: 10.2165/00023210-200115050-00002.
- Asplund, M., Lenhard, F., Rück, C., Andersson, E., Grimlund, T., Nilsson, M., Sarachu-Nilsson, M., Sundh, L., & Ivanov, V. Z. (2025). Therapist-guided internet-delivered acceptance-enhanced behavior therapy for skin-picking disorder: A randomized controlled trial. *Behavior Therapy, 56*(1), 70–82. doi: 10.1016/j.beth.2024.04.006.
- Calikuşu, C., Yücel, B., Polat, A., & Baykal, C. (2003). The relation of psychogenic excoriation with psychiatric disorders: A comparative study. *Comprehensive Psychiatry, 44*(3), 256–261. doi: 10.1016/S0010-440X(03)00041-5.
- Creighton, R., Lazarowitz, R., Bai, J. Q. A., Gupta, S., Sarfaraz, S., Barnawi, G., & Kirchhof, M. G. (2026). Clinical features, psychiatric comorbidities, and treatment outcomes in dermatitis artefacta: A systematic review. *Journal of Cutaneous Medicine and Surgery*. Advance online publication. doi: 10.1177/12034754261437746.
- Farhat, L. C., Reid, M., Bloch, M. H., & Olfson, E. (2023). Prevalence and gender distribution of excoriation (skin-picking) disorder: A systematic review and meta-analysis. *Journal of Psychiatric Research, 161*, 412–418. doi: 10.1016/j.jpsychires.2023.03.034.
- Gerlero, P., Guedes, N. L. K. O., Dwan, A. J., & Nico, M. M. S. (2026). Dermatitis artefacta: A study of 42 patients with management considerations. *Journal of Cutaneous Medicine and Surgery, 30*(1), 41–49. doi: 10.1177/12034754251355589.
- Gieler, U., Consoli, S. G., Tomás-Aragones, L., Linder, D. M., Jemec, G. B. E., Poot, F., Szepietowski, J. C., de Korte, J., Taube, K.-M., Lvov, A., & Consoli, S. M. (2013). Self-inflicted lesions in dermatology: Terminology and classification—A position paper from the European Society for Dermatology and Psychiatry (ESDaP). *Acta Dermato-Venereologica, 93*(1), 4–12. doi: 10.2340/00015555-1506.
- Grant, J. E., & Chamberlain, S. R. (2017). Clinical correlates of symptom severity in skin picking disorder. *Comprehensive Psychiatry, 78*, 25–30. doi: 10.1016/j.comppsych.2017.07.001.

Edición 5, Año 3, Número 2, 2026
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- Grant, J. E., & Chamberlain, S. R. (2020). Prevalence of skin picking (excoriation) disorder. *Journal of Psychiatric Research, 130*, 57–60. doi: 10.1016/j.jpsychires.2020.06.033.
- Grant, J. E., Chamberlain, S. R., Redden, S. A., Leppink, E. W., Odlaug, B. L., & Kim, S. W. (2016). N-acetylcysteine in the treatment of excoriation disorder: A randomized clinical trial. *JAMA Psychiatry, 73*(5), 490–496. doi: 10.1001/jamapsychiatry.2016.0060.
- Jafferany, M., Mkhoyan, R., Arora, G., Sadoughifar, R., Jorgaqi, E., & Goldust, M. (2020). Treatment of skin picking disorder: Interdisciplinary role of dermatologist and psychiatrist. *Dermatologic Therapy, 33*(6), e13837. doi: 10.1111/dth.13837.
- Lavery, M. J., Stull, C., McCaw, I., & Anolik, R. B. (2018). Dermatitis artefacta. *Clinics in Dermatology, 36*(6), 719–722. doi: 10.1016/j.clindermatol.2018.08.003.
- Lochner, C., Roos, A., & Stein, D. J. (2017). Excoriation (skin-picking) disorder: A systematic review of treatment options. *Neuropsychiatric Disease and Treatment, 13*, 1867–1872. doi: 10.2147/NDT.S121138.
- Loftus, H., Cassidy, C., Mun, L., & Jafferany, M. (2025). A systematic review of nonpharmacological treatment options for skin picking disorder. *Clinical and Experimental Dermatology, 50*(2), 299–306. doi: 10.1093/ced/llae366.
- Misery, L., Chastaing, M., Touboul, S., Callot, V., Schollhammer, M., Young, P., Feton-Danou, N., & Dutray, S. (2012). Psychogenic skin excoriations: Diagnostic criteria, semiological analysis and psychiatric profiles. *Acta Dermato-Venereologica, 92*(4), 416–418. doi: 10.2340/00015555-1320.
- Mohandas, P., Bewley, A., & Taylor, R. (2013). Dermatitis artefacta and artefactual skin disease: The need for a psychodermatology multidisciplinary team to treat a difficult condition. *British Journal of Dermatology, 169*(3), 600–606. doi: 10.1111/bjd.12416.
- Schumer, M. C., Bartley, C. A., & Bloch, M. H. (2016). Systematic review of pharmacological and behavioral treatments for skin picking disorder. *Journal of Clinical Psychopharmacology, 36*(2), 147–152. doi: 10.1097/JCP.0000000000000462.
- Teng, E. J., Woods, D. W., & Twohig, M. P. (2006). Habit reversal as a treatment for chronic skin picking: A pilot investigation. *Behavior Modification, 30*(4), 411–422. doi: 10.1177/0145445504265707.
- Torales, J., Ruiz Díaz, N., Barrios, I., Navarro, R., García, O., O'Higgins, M., Castaldelli-Maia, J. M., Ventriglio, A., & Jafferany, M. (2020). Psychodermatology of skin picking (excoriation disorder): A comprehensive review. *Dermatologic Therapy, 33*(4), e13661. doi: 10.1111/dth.13661.
- Torales, J., Malvido, K., Vázquez, M. A., Barrios, I., Almirón-Santacruz, J., Navarro, R., O'Higgins, M., Casas, G., Castaldelli-Maia, J. M., Ventriglio, A., & González-Urbieta, I. (2023). Dermatitis artefacta: A practical guide for diagnosis and management. *Acta Dermatovenerologica Croatica, 31*(1), 17–23.

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