05 - 10.5 Excoriation (Skin Picking) Disorder

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theory, the skin is an erotic

organ, and picking at the skin or scratching the skin leading to excoriations may be a source of erotic pleasure. In that sense it has been considered a masturbatory equivalent. Patients may be unaware of these affects presumed to be in the unconscious. Many patients begin picking at the onset of dermatological conditions such as acne and continue to pick after the condition has cleared. Abnormalities in serotonin, dopamine, and glutamate metabolism have been theorized to be an underlying neurochemical cause of the disorder, but further research is needed. DIAGNOSIS The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) it was called trichotillomania. It was also known as skin-picking syndrome. DSM-5 diagnostic criteria for skin-picking disorder requires recurrent skin-picking resulting in skin lesions and repeated attempts to decrease or stop picking. The skin-picking must cause clinically relevant distress or impairment in functioning. The skin-picking behavior cannot be attributed to another medical or mental condition and cannot be a result of a substance use disorder (e.g., cocaine or methamphetamine use). CLINICAL FEATURES The face is the most common site of skin-picking (Fig. 10.5-1). Other common sites are legs, arms, torso, hands, cuticles, fingers, and scalp. Although most patients report having a primary picking area, many times they pick other areas of the body in order for the primary area to heal. In severe cases, skin-picking can result in physical disfigurement and medical consequences that require medical or surgical interventions (e.g., skin grafts or radiosurgery). FIGURE 10.5-1

Skin-picking disorder. Multiple erythematous and pigmented maculae and crusted erosions on chin. (From Sadock BJ, Sadock VA, Ruiz P. Kaplan & Sadock’s Comprehensive Textbook of Psychiatry. 9th ed. Philadelphia: Lippincott Williams & Wilkins; 2009, with permission.) Patients may experience tension prior to picking and a relief and gratification after picking. Many report picking as a means to relieve stress, tension, and other negative feelings. In spite of the relief felt from picking, patients often feel guilty or embarrassed at their behavior. Up to 87 percent of patients report feeling embarrassed by the picking and 58 percent report avoiding social situations. Many patients use bandages, makeup, or clothing to hide their picking. Of skin-picking patients, 15 percent report suicidal ideation due to their behavior and about 12 percent have attempted suicide. Ms. J, a 22-year-old single woman, presented to a psychiatrist at the urging of her dermatologist because of compulsive picking at the skin on her face. She picked at it every day up to three times a day in sessions lasting from 20 minutes to over an hour. She had massive scarring and lesions on her face. She went to a physician 6 months prior when one of the lesions had become infected. Ms. J began picking her face at age 11 at the onset of puberty. At first, she only picked at acne that formed on her face, but as the urge to pick became greater, she started picking at clear patches of skin as well. Due to the scaring and lesions, Ms. J became increasingly withdrawn and avoided all social engagements. She reported feeling great tension prior to picking and only after she began picking did she feel relief. DIFFERENTIAL DIAGNOSIS The diagnosis of skin-picking disorder cannot be made if the behavior can be better accounted for by another medical or psychological condition. Many medical and dermatological conditions may result in urges to itch and pick at the skin. Conditions include eczema, psoriasis, diabetes, liver or kidney disease, Hodgkin’s disease, polycythemia vera, or systemic lupus. Skin-picking can also be seen in Prader-Willi syndrome (97 percent). A thorough physical examination is crucial prior to psychiatric diagnosis. Skin-picking disorder is similar to OCD and it is associated with high rates of comorbid OCD. The disorders differ in a few ways. Skin-picking disorder is prevalent in females while OCD is equal between genders.

The compulsions associated with OCD are usually driven by intrusive thoughts, while the compulsion to pick the skin is usually not. Although skin-picking generally decreases anxiety, it can also entice pleasure in the patient, which is rarely the case in OCD. Skin-picking in OCD patients is usually the result of obsessions about contamination or skin abnormalities. Skin-picking is commonly seen in body dysmorphic disorder. In one study, 45 percent

of body dysmorphic patients report lifetime skin-picking disorder and 37 percent report having skin-picking disorder secondary to body dysmorphic disorder. The skin-picking in body dysmorphic disorder is primarily centered on removing or minimizing believed imperfection in the patient’s appearance. Substance use disorders often co-occur with skin-picking disorder. Methamphetamine and cocaine use may result in the sensation that something is crawling on the body or under the skin (formication), which can result in skin-picking. In order to make the diagnosis of skin-picking disorder, however, skin-picking cannot be a physiological effect of substance use. Factitious Dermatitis Factitious dermatitis or dermatitis artefacta is a disorder in which skin-picking is the target of self-inflicted injury and the patient uses more elaborate methods than simple excoriation to self-induce skin lesions. It is seen in 0.3 percent of dermatology patients and has a female to male ratio of 8 to 1. It can present at any age, but occurs most frequently in adolescents and young adults. It can present as an aggravation of dermatosis, targeting a variety of skin lesions including blisters, ulcers, erythema, edema, purpura, and sinuses. The morphology of factitious dermatitis lesions is often bizarre and linear, with clear-cut, angulated, or geometric edges. Presence of completely normal, unaffected skin adjacent to the horrific-looking lesions is a clue to the diagnosis of factitious dermatitis (Fig. 10.5-2). In addition, the patient’s description of history of the skin lesions is usually vague and lacks detail about the appearance and evolution of the lesions.

FIGURE 10.5-2 Typical self-produced lesions with scabbing. (From Douthwaite AH, ed. French’s Index of Differential Diagnosis. 7th ed. Baltimore: Williams & Wilkins; 1954, with permission.) COURSE AND PROGNOSIS The onset of skin-picking disorder is either in early adulthood or between 30 and 45 years of age. Onset in children before age 10 years has also been seen. The mean age of onset is between 12 to 16 years of age. There may be a lag of time between onset and actual diagnosis. Because little is known about the disorder, many are unaware that it can be treated. Many times patients do not seek treatment until a severe dermatological or medical condition has developed. Typically, symptoms wax and wane over the course of the patient’s life. Approximately 44 percent of women report that the amount of picking coincides with their menstrual cycle. TREATMENT Skin-picking disorder is difficult to treat and there are few data on effective treatments. Most patients do not actively seek treatment due to embarrassment or because they believe their condition is untreatable. There is support for the use of selective serotonin

reuptake inhibitors (SSRIs). Studies comparing fluoxetine (Prozac) against placebo has shown fluoxetine to be superior in reducing skin-picking. The opioid antagonist naltrexone (Revia) has proven to reduce the urge to pick, particularly in patients who experience pleasure from the behavior. Glutamatergic agents and lamotrigine (Lamictal) have also shown efficacy. Nonpharmacological treatments include habit reversal and brief cognitive-behavioral therapy (CBT). Effective therapy requires both psychological and somatic treatment. In some cases mechanical prevention of skin-picking by different protective measures may be of use in an effort to break the cycle. Psychotherapy at the same time deals with the underlying emotional factors. REFERENCES Grant JE, Odlaug BL, Chamberlain SR, Keuthen NJ, Lochner C, Stein DJ. Skin picking disorder. Am J Psychiatry. 2012;169(11):1143–1149. Grant JE, Odlaug BL, Hampshire A, Schreiber

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