Skin Picking Disorders

19

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Key Features

- Most prevalent in middle aged women (30–50 years).
- Thought to be a part of the Obsessive-Compulsive Spectrum Disorders.
- May commence with inflammatory dermatoses.
- Or may commence in skin de novo as a manifestation of underlying 'stress'.
- May be done in a dissociated state where the patient is not aware of the habit of picking.
- Intense desire to pick/rub or scratch real or imagined lesions.
- Sites affected are usually easily accessible such as the face, upper back, extensors of arms and legs, genitalia and buttocks.
- Anxiety and depression are strongly associated comorbidities.
- Also associated with eating disorders and substance/alcohol abuse.
- Treatment is with management of the skin together with management of the OCD component and any associated comorbidities.

Background

Skin picking disorder may be broadly divided into compulsive and impulsive forms. Most skin picking research concentrates on the compulsive form, which includes trichotillomania and acne excoriee. Compulsive behaviour is defined as repeated

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behaviour with an obsessive ideation component that recurs on a repeated basis and leads to psychosocial comorbidities, social impairment and potentially self-harm. Any attempts to curb the urge can lead to increased psychological tension, triggering the compulsive act.

Compulsive skin picking syndromes are repetitive, sometimes ritualistic behaviours, occurring at regular intervals during the day for a sustained period of time. Patients feel the urge to act and find relief in the activity. Attempts to control the urge cause tension to rise. Although carrying out the skin picking behaviour is not denied, the patient does not always spontaneously admit it. The behaviour is generally related to the relief of tension and can sometimes be pleasurable. There is often an initial reward in terms of reduction of tension or pleasure in the picking behaviour followed by intense feelings of shame, self-disgust and guilt. Most patients experience urges to pick the skin, which are reported as intrusive. Even if there is an underlying skin disease, the symptoms cannot account for the severity of the lesions. Patients may claim an underlying itch, which can complicate the diagnosis.

Impulsive behaviour, in dermatology, consists of isolated or recurrent acts of uncontrolled drives to manipulate the skin, sometimes without an obsessive component, and rapid but short relief. Conscious awareness of the behaviour can vary but patients can engage in this type of self-injury in dissociative states where they may not have full awareness or recollection of the behaviour afterwards. Other factors such as substance abuse, risk-taking behaviour and eating disorders may also be found. Impulsive forms of skin damage disorder can be called ‘non-suicidal self-injury’ where there is no conscious suicidal intent. This may involve biting, cutting, scratching, hitting and burning. However, moderate to severe forms can be associated with suicidal ideation and suicidal attempts. The impulsive form of the condition may not fall within the realm of obsessive-compulsive disorder (OCD) and may occur in the context of abnormal personality development, e.g. emotionally unstable personality disorder.

The DSM-5 classification has listed self-induced dermatoses under the diagnostic group termed as ‘Obsessive-Compulsive and related disorders’. Within this classification system, the impulsive form of the skin picking disorder is separate from the compulsive form.

Clinical Presentation

Lesions may arise from pre-existing skin problems like acne or urticated papules or they may be created de novo. The most common sites of involvement are the face and back, followed by the neck, scalp and ears. The ‘butterfly sign’ is a characteristic feature as the areas of sparing where the patient is unable to reach bear a resemblance to the shape of a butterfly. Most patients use their fingernails to pick or squeeze lesions. Many patients also use instruments such as tweezers and needles.

General Symptoms

Patients may complain of itch, burning, pain, oozing and bleeding. Patients may complain that the symptoms keep them awake at night and that is why they become so tired and sleep deprived. Some patients indicate that their symptoms are persistently in their thoughts and that it is very difficult to ignore the symptoms and the urge to pick at the skin. Other patients (quite commonly) say that they find that they are picking at their skin unconsciously and that when they realise that they have been picking (or a friend or relative points this out to them) they have already damaged their skin quite badly. This then leads to feelings of shame and a sense of loss of control over body functions.

Dermatological Signs

(see Figs. 19.1–19.2)

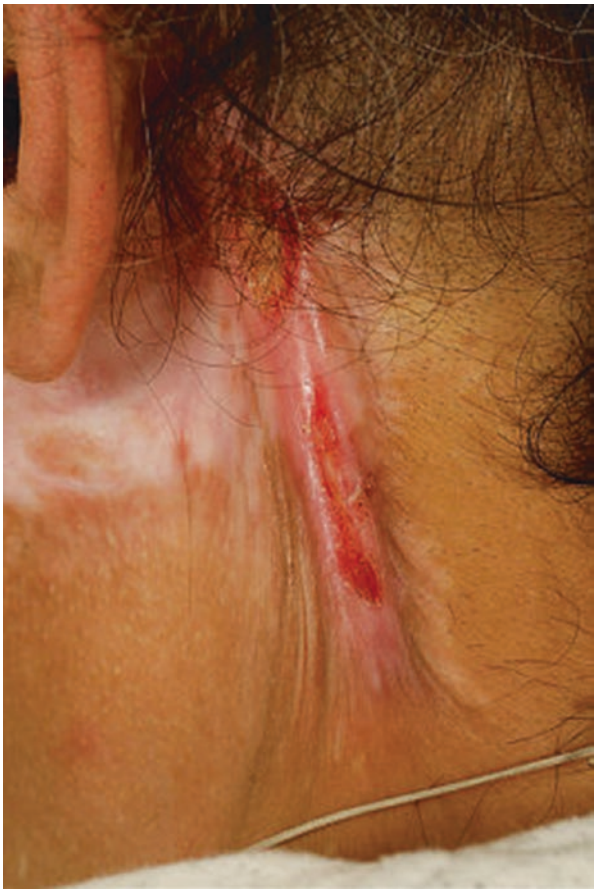

Fig. 19.1 Scarring from extensive skin picking

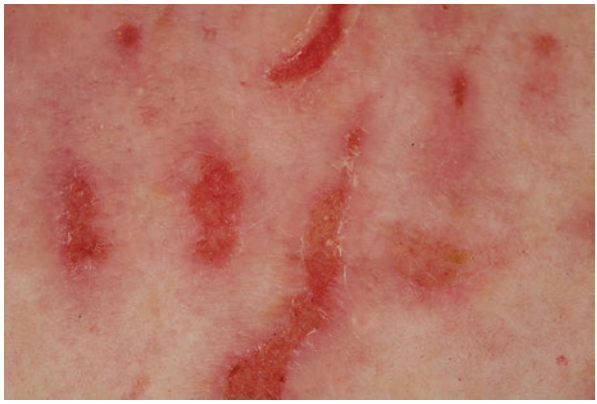

Fig. 19.2 Skin picking can resemble linear tears of the skin

Lesions may range in size from a few millimetres to several centimetres. Lesions can affect any part of the body, but are more common on facial and visible skin. Sometimes the part of the body which is affected can be relevant (e.g. breasts and genitals in patients who have been sexually abused). And sometimes the dominant handedness of the patient can be relevant (e.g. the left side of the body may be more extensively involved in right-handed individuals, and the middle of the back may be spared areas due to its relative inaccessibility). Morphologies vary from superficial erosions to deep ulceration and even alteration of facial and other skin structures. Scarring, post-inflammatory hypopigmentation or hyperpigmentation and all stages of the healing process may be seen. Damage to skin appendages with alopecia and loss of sweating may be a feature. Scarring can be extensive and patients may find that they have severely altered their skin and have a very clear visible difference.

Psychiatric symptoms and comorbidities include

- Anxiety
- Depression
- Suicidal ideation
- Other OCD spectrum disorders
- Body image disturbance and loss of self-esteem
- Body Dysmorphic Disorder
- Eating disorders
- Substance and alcohol abuse

Differential Diagnosis

Skin picking disorder is separate from non-pathological manipulations of the skin such as piercings or tattoos which carry cultural or socio-aesthetic values. Grooming behaviours can also lead to episodic or repetitive skin manipulations which are not pathological and may or may not lead to skin lesions. The distinction between non-pathological and pathological skin picking is not always clear and this is especially in the case with children or in the initial stages of syndromes such as trichotillomania.

Skin picking disorder should be distinguished from other psychiatric or medical conditions which would better explain why the patient would inflict damage on themselves. Psychiatric conditions such as autistic spectrum disorders, schizophrenia, Tourette's syndrome and chronic tic disorders can lead to self-inflicted skin lesions. Delusional infestations can lead to self-inflicted skin damage due to scratching and picking but it would not be considered skin picking disorder as there is a primary psychiatric condition and delusional belief which explain the symptoms. Certain inherited conditions such as Lesch–Nyhan or Prader–Willi syndromes can lead to self-mutilation due to their neurological and behavioural abnormalities. Lesions arising from these conditions should not be considered to be part of the spectrum of skin picking disorder.

Practice Point
Some patients may pick at areas of skin where there is dysaesthesia (e.g. the trigeminal trophic syndrome or post-stroke patients). Localised areas of skin picking may be due to a habit too (e.g. lichen simplex chronicus unilaterally on genital skin; or picker's nodules). Please see chapters on dysaesthesia and trigeminal trophic syndrome.

Practice Point
To differentiate skin picking from Dermatitis Artefacta (and DA related disorders): patients with skin picking will usually (and sometimes reluctantly) admit that they are picking at their skin. They may also indicate that there are some symptoms which lead to their picking habit (e.g. itch or relief when the skin is picked). Patients with DA most commonly do not admit that they are harming their skin in some way and find it difficult to know how the skin damage happened.

Medical Causes of Self-Excoriating Behaviour

- Urticaria
- Uraemia
- Cholestatic hepatitis
- Xerosis
- Cutaneous dysaesthesia
- Porphyria cutanea tarda
- Malignancies

Psychiatric Causes of Self-Excoriating Behaviour

- Depression
- Anxiety
- OCD
- Body dysmorphic disorder
- Borderline personality disorder
- Delusions of parasitosis
- Dermatitis artefacta
- Somatoform disorders such as hypochondriasis

Epidemiology

The true extent of this disorder is unknown as there are only a few studies as to its overall incidence. Adding to the difficulty is the lack of a coherent classification system and the use of various terminologies and descriptions in different studies. Various studies have demonstrated an overall prevalence of between 1.4% and 18% of adults. One study showed that about one in five children reported occasional skin picking with 1.9% regularly indulging in this behaviour and reporting stress regulation difficulties. In a review of 18 studies, the rate of self-inflicted skin lesions ranged from 0.03% to 9.4%. The term, self-inflicted skin lesion is slightly different from skin picking disorder as it encompasses other conditions such as factitious disorder, and it is important to be precise about the exact diagnosis as much as possible. The condition can present at any age but the peak ages of presentation are between 30 and 50 years. There is a distinct female preponderance with a sex ratio of up to 1:3.

Diagnostic Process

Figure 19.3 shows a helpful algorithmic approach to identify the different diagnoses of self inflicted skin disease.

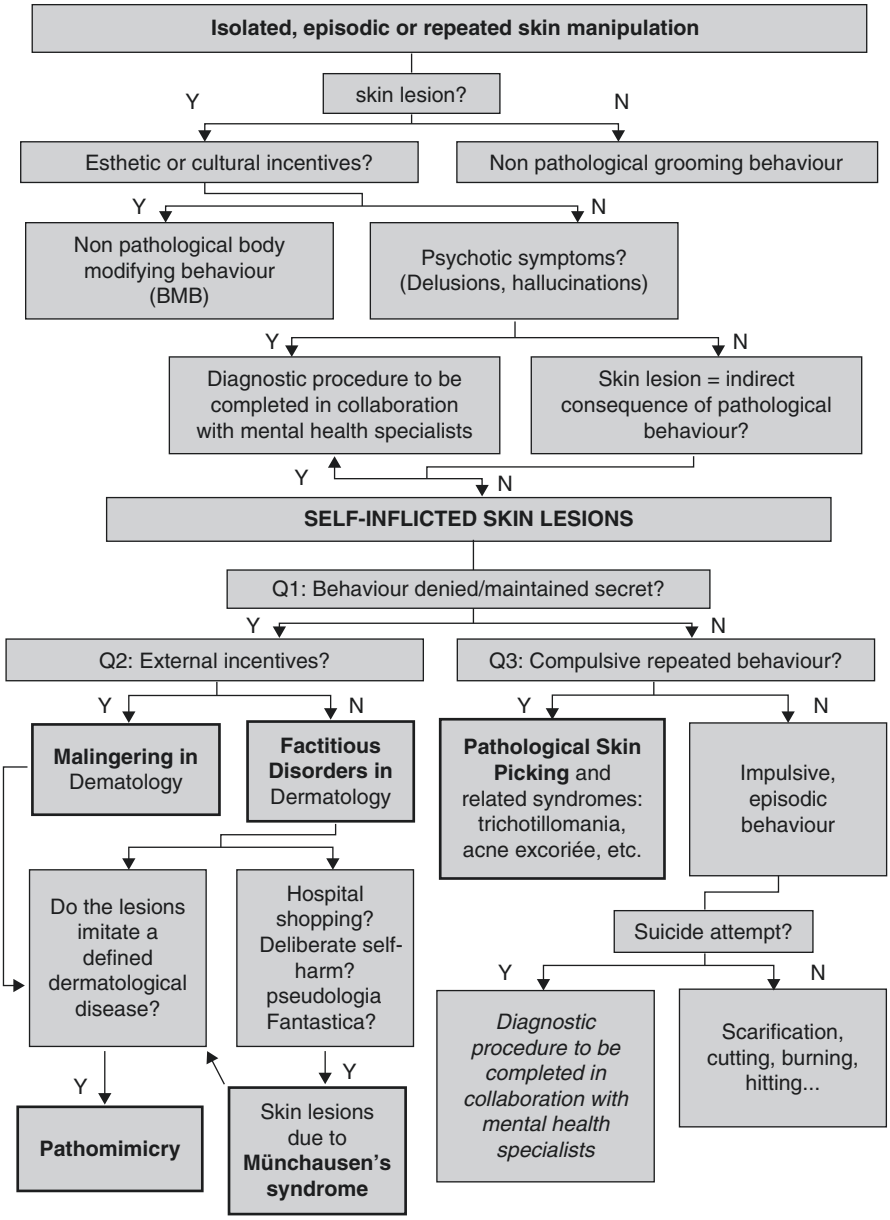

Fig. 19.3 European Society for Dermatology and Psychiatry classification of Skin picking Acta Derm Venereol. 2013 Jan;93(1):4–12

There are three questions that are helpful in correctly classifying abnormal behaviour leading to skin damage.

- Is the behaviour responsible for the somatic damage denied or kept 'secret' by the patient? A 'yes' answer points to a factitious disorder.
- If the answer to the first question is 'yes', are there any external incentives? A 'yes' answer indicates malingering, a 'no' answer points to factitious disorders.
- If the answer to the first question is 'no', is the behaviour responsible for the somatic damage compulsive or impulsive?

Investigations

Only where indicated by the clinical picture, and to exclude organic disease or as part of a pruritus investigation.

- **Blood tests** [Full Blood Count/Thyroid Function Test/Liver Function Test/Renal Function Test/Iron/Ferritin/Glucose], HIV serology and protein electrophoresis as clinically indicated.
- **Skin swabs** for microscopy and culture.
- **Skin biopsies with immunofluorescence** if needed.
- **Other tests** such as Chest X-ray/CT scans depending on the situation for suspected malignancies.

Treatment

Patients presenting with skin picking disorder should ideally be managed in a dedicated psycho-dermatology clinic, with the input of a dermatologist and psychiatrist with access to a psychologist and dermatology nurse specialist. A multidisciplinary approach is important as there may be different therapies treating both skin and mind. Assessment of psychosocial morbidities such as stressful life events and psychological trauma is important as these factors have been shown to have a direct impact on skin barrier function and immune responses. Simply managing the skin lesions does not deal with psychological suffering (Fig. 19.4). There are numerous scales which can be disease-specific such as the Y-BOCS assessment tool, or general quality of life tools such as DLQI and HAD that assess stress and the impact on the skin (see Chap. 30).

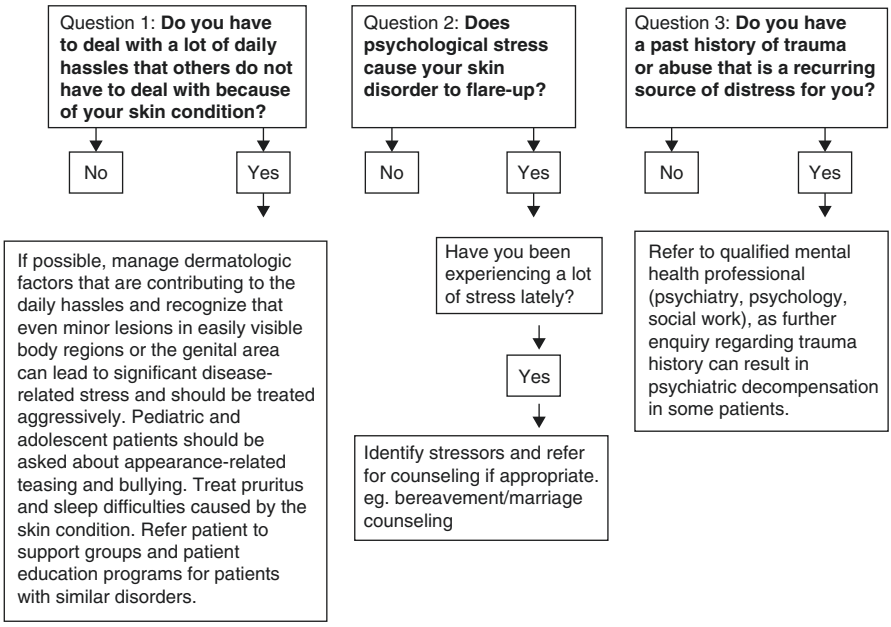

Fig. 19.4 An approach to the assessment and initial management of psychosocial stressors in a dermatology patient (Gupta MA, Levenson JL. The American Psychiatric Publishing textbook of psychosomatic medicine. 2nd edition 2011;667–90.)

Communication

Patients' lack of awareness of the psychological causes responsible for their symptoms can be a challenge in their management. A simplified discussion on stress-reactions in the skin and activation of skin nerves would be a good starting point in getting the patient to consider an holistic approach to their management. A clear statement about the complexity, rather than the difficulty, of the patients' case is recommended. It may also be helpful to explain that although the actual reason for their symptoms is not clearly understood, there are strategies that can be employed which can change the way the skin and brain process the signals it receives.

As with all psychodermatological conditions, patients should be dealt with in a non-confrontational manner. It is unlikely to be helpful for the patients to be told to simply stop the skin-damaging behaviour as they will often have already tried to resist the behaviour. Family members should be advised not to try to simply stop the behaviour unless the patient and the family have come to an agreement about this.

Practice Point
Treat the skin and the psychological disease/comorbidities concurrently
Treat the psychiatric/psychological component with non-pharmacological and pharmacological treatments concurrently where appropriate and acceptable to the patient (as the combination is likely to lead to greater treatment success)

Treatment of the Skin/Itch (See also Pruritus Chapter)

Topicals

Treatment is based on symptom severity. For example, if pruritus is an issue preparations of menthol containing emollients may be useful (e.g. in Menthol in Aqueous Cream) or 5% Doxepin cream. Cool compresses can be helpful to remove crusting and to soothe the skin.

Emollients (patient preference to be considered) with or without antiseptics can also be suggested to improve hydration, and thereby reduce the sensation of itch. A point to note here is that adopting a positive approach in dealing with the skin issues helps enormously as patients invariably become upset if the cutaneous component of their condition is overlooked.

Topical/intralesional steroids/tape to address the inflammatory component of existing lesions can be used as an adjunct for chronic or non-healing lesions. Combinations of antibiotics and glucocorticoids can also be applied in a tapering dose over days or weeks.

Phototherapy and Systemic Treatments

Phototherapy (TL01) for the whole body or localised, can be used with good results especially in cases where widespread itching is a feature. The mechanism of action is through the immunomodulatory and anti-inflammatory effects of phototherapy which leads to itch reduction and improvement of underlying dermatitis.

Antibiotics from the tetracycline group (Lymecycline or Doxycycline) have been tried with benefit where there may be a cutaneous super-infection. Tetracyclines may be preferred for their anti-inflammatory as well as antibiotic effects. Treatment courses tend to last for weeks or months depending on the response.

Conventional sedative antihistamines such as Hydroxyzine or Chlorpheniramine can help with itching. The antipruritic effects of Doxepin may be particularly beneficial for patients with associated depression and anxiety. It can be given in doses of between 10 and 20 mg in the elderly, and up to 75 mg in younger patients.

Treatment of the Psychological or Psychiatric Disease

Non-pharmacological Therapy (See also Chapter on Habit Reversal and Cognitive Behavioural Therapy)

Counselling can be beneficial in those patients who have psychosocial stressors that have precipitated, or are perpetuating their skin problem (e.g. bullying at school, marriage breakdown, bereavement). Cognitive behavioural therapy (CBT) can be very effective for patients with signs and symptoms of OCD, those with affective disease, and who are willing to engage with their psychologist. It involves tailored treatment according to the individual needs of the patient, but is often psychoeducation, thought re-training and cognitive restructuring which consists of helping patients change their habits [for example, through habit reversal training-see Chap. 29 on this] and by changing the perceptions of their appearance.

Other non-pharmacological therapies include Eye Movement Desensitisation And Reprocessing (EMDR), Mindfulness, hypnosis, relaxation techniques, acceptance and commitment therapy and bibliotherapy.

Cognitive behavioural therapy (CBT) is thought to be the most effective treatment for skin picking. There are a range of different talking therapies which may help patients with skin picking disorder, and the choice of which talking therapy is best can be made by the patient and clinician together. One form of CBT, schema therapy, has been used with obsessive-compulsive disorders, and small-group intensive CBT was found to improve obsessive-compulsive symptoms. CBT works by cognitive restructuring which consists of helping patients challenge the interactions of their thoughts, behaviour and feelings. Habit reversal techniques aimed at stopping the obsessive-compulsive disorder seem to have positive outcomes although evidence currently is limited. Cognitive interaction using a diary is another option for patients to become more conscious of their behaviour.

Two systemic meta-analyses have shown that combinations of talking therapies and psychopharmacology may be superior to each therapeutic line in isolation. But, as always in psychodermatology, the patient remains pivotal in the choice of therapeutics and patient-centred therapeutic approaches are likely to have better adherence and outcomes.

A–B–C Model of Habit Reversal for Skin Picking

A: Affect regulation
B: Behavioural addiction
C: Cognitive control

Commonly used psychological treatments in Skin Picking Disorder

Habit reversal
Relaxation techniques (including mindfulness)
Cognitive behavioural therapy
Acceptance and commitment therapy

Less commonly used psychological treatments used in SPD (possibly due to availability or cost)
Hypnosis
Psychodynamic therapy
Eye movement desensitisation and reprocessing (EMDR)

Pharmacological Therapy

Pharmacological Therapy
Commonly used medication
SSRIs, e.g. citalopram or fluoxetine often used in higher doses
SNRIs, e.g. duloxetine, venlafaxine
NaSSAs, e.g. Mirtazapine (watch for weight gain and sedation)
Tricyclics (e.g. doxepin)
Less commonly used
Antipsychotics, e.g. risperidone
N-acetyl Cysteine
Naltrexone
Anti-convulsants
Topiramate

The reader is referred to the chapter on psychopharmacology for more information on psychotropic medications. Obsessive-compulsive symptoms as seen in skin picking disorders have been associated with Serotonin mediated neural pathways. Antidepressants that selectively block serotonin uptake (SSRIs) can be of benefit in patients with this problem. Commonly used SSRIs include Citalopram, Sertraline and Fluoxetine. Mirtazapine, a noradrenergic and specific serotonergic antidepressant (NaSSA), is used primarily in the treatment of depression and has anxiolytic and sedative effects. Mirtazapine has a place on the therapeutic ladder where either the patient cannot tolerate SSRIs or where insomnia is a key feature. Tricyclic

antidepressants may be used (e.g. doxepin, a commonly used tricyclic in this condition, with its potent anti-histamine activity).

Less often used psycho-pharmacological medications such as N-acetyl cysteine (NAC) may be considered if other medications are not effective. Second and third-generation antipsychotics such as risperidone, olanzapine and aripiprazole are occasionally used for severe obsessive-compulsive disorder associated with self-inflicted skin lesions under specialist psychiatrist supervision. Psychiatrists should be involved in these cases. Anticonvulsive drugs such as lithium, carbamazepine, valproate and others are commonly used in bipolar disorder in psychiatry. These can be useful in certain conditions associated with self-inflicted skin lesions where the behaviour is triggered by rapid mood change, but the involvement of a psychiatrist would be required. Naltrexone, normally used in opioid toxicity, may be useful in skin picking disorder associated with severe pruritus. Benzodiazepines can be used very rarely for patients with anxiety but side effects and dependence mean that these drugs are often used only as a last resort or in special circumstances (usually around addiction issues). Topiramate has been used with anecdotal success.

Prognosis

The prognosis depends on a few factors. Predisposing factors, for example anxiety, depression and other psychiatric comorbidities may need to be addressed and dealt with. Further precipitants such as stressful life events may need to be addressed. The average duration of illness is reported to be around 5–8 years with relapses and remissions that parallel stressful situations.

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