

Under-diagnosed Psychiatric Syndrome II: Pathologic Skin Picking

SMK0, *FAMS, MBBS, M Med (Psych)

Abstract

Pathologic skin picking (PSP), previously known as neurotic excoriation, is characterised by habitual and repetitive self-excoriation of skin. Affecting mainly women with onset in the 20s and 30s, it can lead to significant distress, dysfunction and disfigurement. The extent and degree of self-excoriation is reported to be proportional to the distortion of the underlying personality. Because of the close similarity to obsessive compulsive disorder in phenomenology and pharmacological response to the serotonin re-uptake inhibitor (e.g. clomipramine, fluoxetine and sertraline), PSP has been considered as an obsessive compulsive spectrum disorder.

Ann Acad Med Singapore 1999; 28:557-9

Key words: *Itch, Self-excoriation, Skin picking, Treatment*

Introduction

Pathologic skin picking may be defined as the habitual picking of skin lesions, which when chronic and extensive, can lead to significant distress, dysfunction and disfigurement. The underlying skin lesions may range from benign ones, e.g. barely noticeable irregularities of the skin, to more severe ones, e.g. acne, eczema, scabs, insect bites or wounds. Even though Erasmus Wilson¹ first introduced the term neurotic excoriation in 1875 to describe this condition, there has been a dearth in subsequent literature, and the subsequent ones were as recent as only 25 years ago.²⁻⁶ It is often considered a dermatological syndrome characterised by repetitive self-excoriation of skin; yet, unlike other self-inflicted dermatoses, such as dermatitis artefacta and malingering, the patient acknowledges the self-inflicted nature of their lesions.⁵ In dermatitis artefacta, there is often extensive cutaneous excoriations which the patient denies are self-inflicted lesions.⁵ In malingering, the person consciously carries out cutaneous self-mutilation with a clear intention to obtain gain; that is distinctly absent in dermatitis artefacta and neurotic excoriation.

Incidence

It is the author's impression that pathologic skin picking is probably under-diagnosed by clinicians locally. Depending on the population studied, the incidence varies from 2% incidence of neurotics among dermatology clinics⁷ to a high 9% prevalence among inpatients with pruritus.⁸ Almost all studies showed

that females^{3,9-11} are more commonly affected, with a mean age of onset in the 20s and 30s.^{2,4}

Aetiological Factors

Psychodynamic theory proposes that this condition arises primarily from conflict situations and distress, resulting in blockages of drives and needs. Such persons often have high reserves of aggression, yet experience difficulty venting the easily aroused aggressive impulses. This stems in part from compulsively restrictive and punitive parents, and perhaps also from vulnerability on loss of love and social status. Scratching acts as an outlet for repressed aggressive impulses, and as self-punishment because of guilt related aggressive impulse. It is conceived as an imperative urge to remove cutaneous irregularities because of this symbolic significance, or as a benign form of masturbation.³ The results of a controlled electroencephalographic (EEG) investigation¹² seemed to support the hypothesis that relatively unmasked aggression plays a greater pathogenic role for neurotic excoriation patients than for "usual neurotics" with EEG abnormalities reported in 52% of the latter group against 25% of controlled subjects.

In a controlled psychiatric examination of 63 patients with neurotic excoriation, Fruensgaard³ reported that three quarters seemed to lack self-confidence and were hypersensitive in their personality. 60% were apprehensive/reserved, and two-thirds were meticulous or perfectionistic. Frequent depressive/dysphoric mood was also reported in two-thirds of the patients.

* Associate Professor and Consultant
Department of Psychological Medicine
National University of Singapore

Address for Reprints: A/Prof Ko Soo Meng, Division of Stress Medicine, Department of Psychological Medicine, National University of Singapore, c/o National University Hospital, 5 Lower Kent Ridge Road, Singapore 119074.

Clinical Features

There is considerable disagreement on whether the itch or urge to scratch comes first. It often begins with a "disturbing sensation" in the skin, distinct from pruritus,¹³ an itch itself, or just an urge to scratch some benign skin irregularities.^{3,10,14} An itch-scratch cycle is initiated, and self-perpetuating, and this becomes a compulsive ritual in some patients.^{3,14} Scratching tends to occur at night when the itch threshold is lower,¹⁵ or when the person is unoccupied, and in areas where it can be reached—typically the face, upper back, upper and lower extremities. The lesions are unremarkable, usually only a few millimetres in diameter, weeping, crusted or scarred, with post-inflammatory hypopigmentation or hyperpigmentation.

The extent and degree of self-excoriation is reported to be proportional to the distortion of personality.¹⁴ Perfectionistic or obsessive compulsive traits,^{3,4,10,16} anxiety,^{3,16} depression,^{3,9,16} conversion reactions,^{9,16} hysteria,¹⁰ hypochondriasis³ and paranoid schizophrenia,¹⁴ have all been documented in association with this syndrome. Similarly, psychosomatic syndromes are common association—with one third of these patients reporting tension or migraineous headaches and gynaecological symptoms related to menstruation.³ It is possible that in some instances, there is an underlying somatization disorder.⁵ Difficulty with the expression of anger is commonly reported.^{3,13,14,17,18} Psychological stress has been reported to precipitate this condition in 33% to 98% of patients.^{3,16,19}

Treatment

In addition to topical dermatological preparations for symptomatic treatment of cutaneous lesions and relief of secondary pruritus, the treatment of this disorder is primarily psychiatric and largely incomplete without it. Like patients with a somatization disorder, these patients often refuse psychiatric intervention initially. An empathic, supportive approach seems more effective than insight-oriented psychotherapy.^{9,18}

Benzodiazepines,² antidepressants like amitriptyline⁹ and clomipramine,⁵ and even anti-psychotics especially pimozide²⁰ have been reported in the clinical management of this chronic condition, but with less than remarkable results. In the first reported controlled, double-blind study of fluoxetine versus placebo of 17 subjects, fluoxetine was found to be effective in 2 out of 3 outcome measures.²¹ This improvement was independent of change in other psychopathology such as anxiety, depression, or obsessive compulsive symptoms. Interestingly this trial showed similarities to that of obsessive compulsive disorder with approximately 40% to 60% clinical improvement of the condition and the delayed onset of response (around 6 weeks of treatment). Based on pharmacological response and

phenomenological similarities, one may consider pathologic skin picking as an obsessive compulsive spectrum disorder.²¹⁻²³ Sertraline, the other selective serotonin re-uptake inhibitor has also been found to be efficacious in this disorder.²⁴

Course and Prognosis

Pathologic skin picking often runs a chronic course—majority of cases for 10 to 12 years.³ Prognosis is only better if symptoms have been present for less than a year,⁵ with improvement of mental state once the cutaneous lesions have improved.⁵

Conclusion

Although it seems reasonable to conclude that pathologic skin picking is a form of self-destructive behaviour, its relation to more serious deliberate self-harm like suicide is unknown. Skin picking is not classified in the Diagnostic and Statistical Manual of Mental Disorder with trichotillomania and other impulse control disorders. Yet, there appears to be definite similarities between skin picking and hair pulling in age at onset, sex ratio, clinical course and characteristics of the behaviour such as frequency pattern, mounting tension and relief / gratification.²¹ Studies also suggest comorbidity and family history links between the two behaviours.²³ Simeon et al²¹ suggest that perhaps pathologic skin picking and trichotillomania are biologically distinct conditions, but the former may be more closely related to obsessive compulsive disorder.

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