Exploring the Interdisciplinary Roles of Dermatologists and Psychiatrists in the Management of Excoriation (Skin-picking) Disorder

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ABSTRACT

Excoriation disorder is a mental health disorder characterized by excessive picking of one's skin resulting in clinically significant functional impairment. Diagnosing this condition has been historically challenging due to the varied associated behaviours and lack of inclusion in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). As dermatologists and psychiatrists are the specialists most likely to encounter these individuals, this article discusses the new *DSM-5* criteria and outlines the approaches and treatment options for these specialists to optimally manage patients with excoriation disorder.

RÉSUMÉ

L'acné excoriée est un trouble de santé mentale caractérisé par le grattage et l'arrachage excessif de la peau qui mènent à une dysfonction clinique significative. Le diagnostic précis de cette condition demeure un défi lorsqu'on tient compte de la variété des comportements qui y sont associés et le manque d'inclusion des caractéristiques de ce problème de santé dans le *DSM* (*Manuel diagnostique et statistique des troubles mentaux*). Étant donné que les dermatologues et les psychiatres sont les spécialistes les plus susceptibles de traiter ces problèmes de santé mentale, cet article présente les nouveaux critères du *DSM-5* et décrit les grandes lignes cliniques, les approches nécessaires et les options de traitement afin que ces spécialistes puissent intervenir auprès des patients avec l'acné excoriée de façon optimale.

INTRODUCTION

Excoriation disorder (also called psychogenic excoriation, dermatillomania, pathologic or compulsive skin picking, neurotic excoriations, or acne excoriée) [1-2] is characterized by repetitive and compulsive picking of one's skin. This frequently causes tissue damage leading to infection, scarring, ulcers, and physical disfigurement [3]. Common locations include the face, arms and hands, but any area on the body can be targeted [4-5]. Typically, patients with this disorder start picking due to a dermatologic condition such as acne vulgaris, but eventually continue to pick even when the skin is normal [4,6]. While "mild" skin picking is fairly common in the general population, pathologic skin picking has been documented to have a prevalence of 2% in dermatology patients [7], 4% in college students [8] and 5.4% in the community [9]. The disorder is more common in females and has a bimodal age of onset, appearing more often in late childhood to early adolescence and between the ages of 30–45 years [10-11].

Excoriation disorder has recently received new diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorder* (*DSM*). Under the previous *DSM-IV-TR*, excoriation disorder was classified under 'impulse control disorders not elsewhere specified'. In accordance with an impulse control disorder, most patients report acting automatically and experiencing tension prior to picking and subsequent relief or pleasure afterwards [6]. However, under the new *DSM-5*, excoriation disorder is now classified under a new diagnostic group called 'obsessive compulsive and related disorders' to reflect the growing body of evidence that it is also ritualistic, ego-dystonic and highly co-morbid with obsessive compulsive disorder (OCD), body dysmorphic disorder (BDD), and trichotillomania (hair-pulling) [12]. To be diagnosed according to the *DSM-5* criteria, the individual must have made repeated attempts to decrease or stop the skin picking, which causes clinically significant distress or functional impairment, and the skin picking must not be better explained by symptoms of another mental disorder [12].

Although excoriation disorder is a psychiatric condition at its core, these patients are more frequently seen at dermatology clinics. Shame and embarrassment towards skin picking may prevent patients from seeing a psychiatrist. Thus, dermatologists should be aware of this condition in order to mediate a referral to psychiatry and potentially even provide initial treatment. This article will examine the roles of these two specialties in managing excoriation disorder and how interdisciplinary care in the form of combining different treatment approaches can improve the overall management of this distressing condition.

Keywords: Excoriation disorder; Psychogenic excoriation; Dermatillomania; Neurotic excoriations; Pathologic skin picking; Compulsive skin picking

Table 1. Fried and Fried's 10 diagnostic categories of pathologic skin pickers [14].

Category of Pickers	Clinical symptoms	Recommended treatment
Angry	Underlying anger often expressed through sarcasm and passive aggressiveness (i.e., skin picking)	Anger management techniques with concomitant use of SSRIs or anxiolytic medications
Anxious/depressed	Feelings of tension, fatigue, or sadness that are transiently decreased with skin picking	SSRIs or TCAs for depressive symptoms; benzodiazepines for acute anxiety
Body dysmorphic	Preoccupation with a minimal or imagined defect in appearance	SSRIs and adjunctive psychotherapy
Borderline	Significant emotional instability, chronic feelings of emptiness, boredom, unhappiness, poor judgement, limited impulse control	Long-term psychotherapy; anxiolytic and antipsychotic medications during acute episodes; very difficult to treat
Delusional	Rigidly held belief that is not based in reality (e.g., skin infestation or skin defect)	Pimozide, olanzapine, risperidone; standard antipsychotic medication and psychiatric hospitalization for more generalized symptoms
Guilty	Fearful, guilt-ridden individuals picks as a self-punitive measure to rid oneself of impurity or imperfection	Proper education about the nature of the condition; gentle reassurance and humour
Habit	Picks to reduce underlying anxiety without any associated obsessions or compulsive behaviours	Behaviour modification, hypnosis, standard dermatologic treatments
Narcissistic	Inability to accept imperfection, spend hours studying themselves in a mirror; pick as an attempt to rid themselves of "an intolerable stain on an otherwise perfect image"	Emotional support and reality-based objective assessments of the imperfections; very difficult to treat
Obsessive compulsive	Intrusive, obsessive thoughts accompanied by compulsive, ritualistic behaviours	SSRIs with concomitant CBT (exposure and ritual response prevention)
Organic	Picks in response to an itch or cutaneous dysesthesia	Treat underlying condition

SSRI: selective serotonin reuptake inhibitor; TCA: tricyclic antidepressant; CBT: cognitive behavioural therapy

THE DERMATOLOGIST

It is challenging for dermatologists to manage those who pick their skin. Patients are often ashamed and embarrassed of their behaviours and attempt to downplay the severity of their condition when interviewed [13]. These patients are also more likely to have co-morbid psychiatric conditions, which lie outside the expertise of the dermatologist. Prior to the inclusion of excoriation disorder in the *DSM*, the lack of any organic cause for skin picking led patients to be inappropriately labelled as "crazy pickers and scratchers" [14]. This inevitably made it difficult for the dermatologist to determine the underlying problem or to formulate an adequate treatment plan. Now with the classification of excoriation disorder in the *DSM-5*, objective evidence of its legitimacy as a medical disorder exists. The goal for the dermatologist then is to develop an approach for these patients during the first encounter and to initiate the therapeutic process.

Fortunately, there are several articles in the literature that provide guidance for dermatologists managing patients with excoriation disorder. Fried described a "three-level approach" comprising of a lesional level, emotional level and cognitive level [15]. At the lesional level, traditional dermatologic treatments such as occlusion, topical or intralesional corticosteroids, mentholated compounds, tar preparations, emollients, and cryosurgery can be helpful in both treating any skin lesions or complications and deterring patients from engaging in their picking behaviours [14-15].

The emotional level utilizes a "listen, ask, tell" approach to understand the patient's mental status [15]. By *listening* to the patient, it will allow the dermatologist to get a better understanding of *why* the individual picks their skin. This information will then allow for determination of other possible co-morbid psychiatric conditions (e.g., anxiety, depression) that may explain their pathologic behaviour [15]. At this point a differential diagnosis can be created and the dermatologist may proceed to the *ask* phase. Here, a series of focused questions can determine the severity of the emotional symptoms and whether there is a negative impact on daily functioning [15]. This will determine if there

Table 2. *DSM-5* criteria for excoriation (skin-picking) disorder under the Obsessive-Compulsive and Related Disorders category [12].

- Recurrent skin picking resulting in skin lesions.
- Repeated attempts to decrease or stop skin picking.
- The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The skin picking is not attributable to the physiological effects of a substance or another medical condition.
- The skin picking is not better explained by symptoms of another mental disorder.

is a clinically significant disorder that needs to be treated. Additionally, it is important to screen for risk of suicide. Lastly, it is important to *tell* the patient that their struggle with skin picking is very real and that treatment options are available and effective [15]. The aim of the "listen, ask, tell" approach is to create a strong therapeutic alliance, providing both emotional support and a sense of hope for the patient.

The cognitive level attempts to put patients back in control of their own body and mind [15]. These individuals commonly believe that their skin picking is entirely their fault, a pervasive belief often stemming from underlying guilt. An effective strategy to shift the blame away from the patient is to provide education about the condition with particular emphasis on the biologic component to their behaviours [15]. The patient will be more willing to accept this type of explanation compared to a psychogenic cause and should be more eager to seek pharmacological treatment. As well, this level explores the opportunity for the dermatologist to propose alternative behaviours to skin picking, such as squeezing their fists or practising deep breathing techniques when patients feel the urge to scratch [15]. This shows the patient that the physician is aware of their urges and can provide meaningful solutions instead of simply saying, "you should stop picking" [14-15].

This "three-level approach", based on the biopsychosocial model of disease, provides dermatologists with the appropriate tools to initially manage excoriation disorder. Addressing the lesional, emotional and cognitive aspects of this complex condition will hopefully create a comprehensive assessment and a strong therapeutic alliance with the patient. Fried's approach has been utilized in numerous articles since its original publication and continues to be one of the few non-pharmacologic approaches recommended for dermatologists in the literature [6,16].

In a more recent article, Fried and Fried expanded on the original approach to divide skin pickers into ten categories based on emotional states such as anxious/depressed or obsessive compulsive (Table 1) [14]. Conceptualizing patients into a particular subgroup provides a framework for non-psychiatrists to tailor specific treatments [14]. However, this strategy relies on the dermatologist to become comfortable prescribing psychiatric medications. Therefore, it is suggested that dermatologists become familiar with starting one or two agents such as a selective serotonin reuptake inhibitor (SSRI) or benzodiazepine at a low dose [14]. Of note, the American Academy of Dermatology Task Force on Psychocutaneous Medicine endorses these medications and supports their use whenever necessary [14].

Despite his or her best efforts, the patient with excoriation disorder may have to be referred for psychiatric evaluation and treatment. It is important that the dermatologist be aware of the psychiatric services involved in their community and, if available, psychiatrists specializing in psychocutaneous disorders. This knowledge, along with expressing empathy and a sense of hope, will encourage these individuals to seek appropriate treatment and feel validated in their journey towards managing their condition.

THE PSYCHIATRIST

It is important to first understand that patients with excoriation disorder rarely seek treatment. In a study of 31 patients with this condition, 45% actively sought treatment, and of that group only 19% sought dermatologic treatment despite obvious infections or visible craters [13]. While this may be due to shame or the perception that the condition is untreatable, it may also stem from the fact that until recently, it was not recognized as a psychiatric disorder with its own criteria for diagnosis. Excoriation disorder is now included separately in the *DSM-5* as an obsessive compulsive and related disorder, and psychiatrists should expect to see more patients with this disorder referred to their practice as awareness of this condition increases among family physicians and dermatologists. The role of the psychiatrist in the management of these patients will involve assessing for the condition and any other co-morbid disorders, and providing treatment in the form of pharmacotherapy and psychotherapy.

Table 2 shows the *DSM-5* diagnostic criteria for excoriation (skin-picking) disorder under the obsessive compulsive and related disorders category [12]. A key criterion is that symptoms must not be better explained by another mental disorder. Excoriation disorder is commonly misdiagnosed as OCD or BDD due to the overlap of features [17]. These conditions are now under the same category in the *DSM-5*; thus, psychiatrists should be aware of the key differences between the disorders in order to make the appropriate diagnosis. These differences include the presence of an obsession (intrusive thoughts that cause significant

anxiety) and/or compulsions (a repetitive behaviour that is performed in response to the obsession) as seen with OCD, or the presence of repetitive behaviours in response to preoccupations with an imagined defect in appearance as seen with BDD [12]. As well, there are many other co-morbid mental disorders that may require formal diagnosis. Certain personality disorders such as obsessive-compulsive personality disorder and borderline personality disorder are often associated in these patients, occurring in 71% of patients in one study [13]. Mood and anxiety disorders are also highly prevalent, ranging from 48–68% and 41–65% of these patients, respectively [13]. The proper diagnosis of excoriation disorder and other mental disorders will prove helpful for both the patient and the psychiatrist, with the latter being more equipped to formulate appropriate treatment plans.

Various studies have shown the effectiveness of common psychiatric medications for excoriation disorder. SSRIs have been studied the most due to their traditional use in OCD [3]. In particular, fluoxetine has been shown to be significantly more effective than placebo in reducing skin picking behaviours in two randomized controlled trials (RCTs) [18-19]. These results were seen within 2 to 4 weeks of treatment at a daily dose of 20mg or 40mg, reaching as high as 80mg in more clinically resistant patients [18-19]. Other SSRIs that have been examined in open label studies include fluvoxamine [20], sertraline [21] and escitalopram [22], which have all demonstrated some effectiveness in improving skin excoriations. The anti-epileptic drug lamotrigine has also been shown to be effective in an open-label trial [23]. Although further RCTs of other pharmacologic agents may be beneficial, numerous options are currently available with promising results. Treatment of other co-morbid disorders must also be considered to manage the patient beyond their skin excoriations.

Psychotherapy, in particular cognitive behavioural therapy (CBT), has been less studied in the treatment of excoriation disorder. In the literature, there is only one RCT that studied the habit reversal technique [24]. This individualized therapy involves numerous steps: 1) response description (patient describes and demonstrates the picking behaviour); 2) early warning (patient is taught to notice hand movements towards areas of excoriation); 3) situation awareness training (patient becomes aware of situations or stressors associated with the urge to pick); 4) habit inconvenience review (patient is educated about the negative consequences of their behaviour); 5) competing response practice (patient learns exercises that are incompatible with their picking such as clenching their fists); 6) generalization training (patient learns to perform these exercises without disrupting daily activities); and 7) symbolic rehearsal (patient practices these exercises in front of the clinician) [24]. Patients practicing the habit reversal technique experienced a decrease in the urge to pick and a reduction in the amount of skin picking behaviours by 77% after one month compared to those who did not receive this therapy (16%) [24]. These results were also sustained at a 3- to 4-month follow-up, maintaining a decrease of 77% versus 27% [24]. This technique shows promise and may provide an alternate treatment option with sustainable results, although further studies are required before it becomes more widely employed.

CONCLUSION

Excoriation (skin-picking) disorder is a legitimate and prevalent psychiatric disorder in society. With its inclusion in the *DSM-5*, diagnosing and treating this condition has become clearer and more objective for any health care professional involved. Both dermatologists and psychiatrists have unique roles and approaches in managing these patients, and when combined as effective interdisciplinary care, yield optimal therapeutic outcomes. As further treatment options are discovered and more non-psychiatrists become comfortable assessing those with skin excoriations, patients with this condition will be able to receive appropriate care and regain control of their mind and skin.

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