

A Case of Skin Picking Disorder of a Patient with a History of Childhood Abuse

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ABSTRACT

Skin picking (excoriation) disorder is the recurrent excoriation of one's own skin, resulting in noticeable skin damage. People pick their skin for different reasons. For the majority of patients, first skin picking is associated with a history of childhood abuse and personal problems. Subjects who moderately to severely cause injurious self-harm are more likely to have a history of exposure to domestic violence and childhood abuse than those who do not self-harm. At the same

time, these conditions could be related to the etiology for majority of other psychiatric disorders. We report herein, a case of a patient with skin picking disorder who had a history of childhood physical and emotional abuse with borderline personality disorder.

Keywords: Self-injurious behavior, psychogenic skin excoriation, skin picking disorder, borderline personality disorder, childhood abuse

INTRODUCTION

Compulsive self-injurious behavior (SIB), including hair pulling, nail biting, skin picking (SP), and scratching, is habitual, repetitively occurs, and is frequently observed as a comorbid condition in various psychiatric disorders, such as borderline personality disorder (BPD), post-traumatic stress, depressive, anxiety, and eating disorders (1). SP disorder (SPD), also known as neurotic/psychogenic excoriation, involves pathological SP and dermatotillomania, which is characterized by recurrent and excessive skin picking or scratching, and this disorder has been recently introduced to The Fifth Edition of The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as an obsessive-compulsive-related disorder (2). Women are more likely to be affected than men (3). The prevalence of SPD has been found to be 1.25%–5.4% of the adult population (3), 2.4% of Turkish students (4), and 11.8% of adolescent psychiatric inpatients (5).

Childhood abuse is associated with various psychopathologies, including personality disorders, maladaptive and impulsive behaviors, and SIB in adolescents and adults (6,7). Individuals with compulsive skin picking often present with a history of childhood abuse (6,7,8). The pathophysiology of this association is not well understood (5,7). Regardless of the reason, the known rates of SPD are becoming more prevalent; however, no one treatment has been found to be the most effective. Early childhood trauma leads to a negative self-image, decreased self-esteem, and feelings of incompetence (6,7). Moreover, most patients have a poor impulse control (5,8). Pathological SP behavior often results in important functional deterioration and boredom (5,7,8). The afflicted subjects mostly report shame and embarrassment, along with the avoidance of social situations.

Skin picking disorder can present as a diagnostic puzzle to psychiatric professionals. Nevertheless, the psychosocial consequences of this problem have increasingly received recognition (3,4). Here, we report a case of a 26-year-old female with SPD who had a history of childhood abuse and a diagnosis of BPD.

CASE

A 26-year-old, right-handed, Turkish single female, who lived with her family in a village located in the southeastern part of Turkey, was admitted to our outpatient department of psychiatry. She began SP sporadically and presented with complaints of excessive skin scratching and SP of the fingers, forearms, and upper back for the last 3 years. However, in the past 2 years, the picking had been a daily routine, which was associated with emotional stress, followed by a feeling of relief after picking (Figure 1a; 1b). She had been treated for the numerous skin excoriations by her general practitioner and dermatologist for approximately 2 years, although none of the therapies provided a complete clinical result.

At the time of her admission to our department, the patient was not on medication and reported no previous psychiatric treatment history for SP. She had a remote history of childhood physical abuse by her parents. Prior to when she was 13 years old, the father of the patient had suffered an industrial accident, after which he was unemployed. Unfortunately, since then, a poor economic status and domestic violence,

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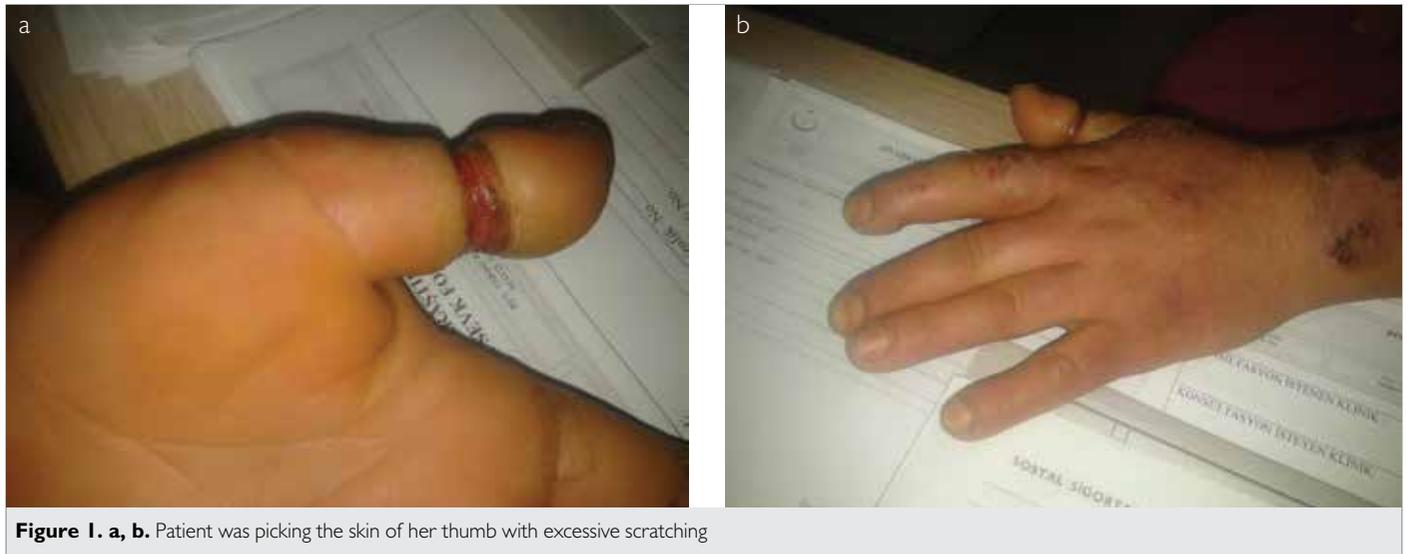


Figure 1. a, b. Patient was picking the skin of her thumb with excessive scratching

both physical and emotional, started at their home. Because of increased stress at home during that period, our patient was exposed to repeated domestic violence. Our patient had ongoing anger for her father and mother and said that her childhood environment was highly stressful and lacked support systems. She accused her parents of being disinterested in her complaints during her adolescence and childhood.

The patient received a comprehensive psychiatric evaluation by experienced researchers to determine the differential diagnosis. During the psychiatric examination, she appeared to act her stated age. However, she was very restless and appeared to be anxious regarding her appearance because of the skin lesions. She was awake, alert, and oriented to people, place, and time. Eye-to-eye contact was initiated but not maintained. Initially, the patient stated that she was feeling depressed with a sad effect. At the same time, her mood was depressed, and her thought content was remarkable in terms of helplessness and worthlessness with anhedonia. The patient denied any perceptual disturbances, and delusions were not elicited. Her insight and judgment were complete. She told us regarding her unstable moods with impulsive behavior and pervasive pattern of instability of interpersonal relationships. Moreover, the patient reported chronic feelings of boredom and loneliness since her adolescence, with feelings of guilt about her SP behavior. She did report a sense of enjoyment from this behavior despite acknowledging its unsightly consequences; however, she could not stop picking. She avoided going to public places at times. She noted that wearing gloves to bed reduced the picking.

On physical examination, no significant abnormalities were noted in general or systemic examinations, apart from skin lesions on the fingers and forearms (Figure 1a, b). She denies any history of itching, insect bites, exposure to new medications or jewelry, allergies, recent change in medications, or travel. In addition, her skin biopsy did not reveal any features of dermatological disorders. Her family history of SP was unremarkable.

Eventually, we diagnosed her as having SPD with BPD as per DSM-5, as is often observed in skin pickers (2,6). No other psychiatric diagnoses were confirmed by the structured clinical interview. The patient began treatment with 20 mg/day fluoxetine and additionally initiated a selected habit reversal therapy (HRT) coupled with cognitive behavioral therapy (CBT) (e.g., psychoeducation, cognitive restructuring). She was followed up every 2 weeks. The dose was increased to 40 mg/day at the end of 4 weeks, and then, she remained on the same dose for 2 more weeks, but

we initiated 1 mg/day risperidone, followed by the dose being titrated at 2 mg/day at the end of 8 weeks. We proposed that the patient should be using the instant replay technique to recall sensations the next time to catch herself earlier, such as whenever her hand moved toward her skin of the forearm or fingers to pick the skin. Furthermore, she started a SP diary to identify situational triggers of habitual SP and noted each time she picked her skin. On follow-up, she showed some improvement; she had reduced anxiety, spent less time SP, and reduced frequency and intensity of SP. Eventually, she was able to completely master her tendency to pick her skin (Figure 2a, b). She is regularly following up in our department and is well maintained on this treatment, at the end of 11 months. Written informed consent was obtained from the patient for publication of this case report and any accompanying images.

DISCUSSION

Based on previous literature, physical, verbal, sexual, and emotional abuses during childhood are common experiences among those who self-injure (6-8). In similar studies, it has been reported that women with SPD are more likely to have a poor self-esteem and impairments in academic performance with more overall dysfunction than men (1,4). Self-excoriation may be a manifestation of emotional immaturity or an immature personality. Moreover, relational difficulties are most at risk when conflictual events and stresses occur and serve as an appeal for help (3,5,7). For patients with SPD with a history of posttraumatic stress and childhood abuse, the causes of psychogenic excoriations can relate to picking as a means of resolving stress or as noted, to some underlying psychopathology (6,7,8).

A borderline skin picker is characterized by enormous effective instability, chronic feelings of emptiness, boredom, and unhappiness (4,6,8). SPD are more often the result of unconsciously motivated repetitive behavior; and scratching is caused by different motivations (3,4,6). As in our case, experiencing childhood abuse can lead to emotional and relational vulnerabilities, which in turn create the need for SIB as a maladaptive coping strategy (5,7).

Findings from clinical samples support the role of a childhood history of abuse as the risk-factor of SPD and these condition could be related to the etiology for a majority of other psychiatric disorders (1,3,6,8). Studies reported a high incidence of lifetime major depression and anxiety disorders and obsessive-compulsive personality disorders and BPDs in skin pickers (1,5,7,8). Our case supports the findings of previous case reports; SPD is possibly associated with a high rate of psychiatric comorbidity. In



Figure 2. a, b. Patient was completely healed in terms of the picking on the thumb skin after the treatment

addition, this case supports the literature that BPD, history of childhood physical and emotional abuse, lower income, and female gender are more associated in pathological SP, as in previous case reports (1,4,5,6,8).

Pathological SP behavior can respond to selective serotonin (5-hydroxytryptamine) reuptake inhibitors and to dopamine-blocking psychotropic drugs (3,9). Current treatment approaches primarily entail the use of psychotropic drugs and HRT coupled with CBT for skin pickers (3,8,9). Moreover, habit reversal coupled with CBT has been suggested as a promising behavioral treatment for self-injurious SP, given its effectiveness in treating problematic habitual behaviors (1,3,8,9). Furthermore, CBT helps individuals identify and change self-defeating thoughts and perceptions that lead to negative emotional reactions and maladaptive behaviors (8,9). This case is consistent with previous case reports on SP behavior that suggest SP can be associated with significant distress (8). Probably, our patient was used to obtaining relief from the stress by this action. Our treatment consisted of habit reversal coupled with CBT implemented during an initial 45 minute session and in additional half-hour sessions during the subsequent 7–8 weeks. During the treatment, the frequency of SP decreased first, followed by improvements in the anxiety level with emotional distress.

Consequently, at 11 months, our patient continued the same medical treatment and was satisfied with the results (Figure 2a, b). Of note, though, is that this case report shows that patients can respond to HRT coupled with CBT, which can be additionally used to psychotropic agents, despite the patient having a history of childhood abuse and SP with psychiatric comorbidity.

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