

## CLINICAL REPORT

# Psychogenic Skin Excoriations: Diagnostic Criteria, Semiological Analysis and Psychiatric Profiles

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Psychogenic excoriations are also called neurotic excoriations, dermatillomania or skin picking syndrome. We proposed diagnostic criteria and then performed a study of the psychiatric profiles of outpatients with psychogenic excoriations and the circumstances around the creation of these excoriations. Although the results must be interpreted with caution because the study was performed with only 10 patients, interesting data is provided about the onset of psychogenic excoriations, the behaviour of picking, and comorbidity. Common or specific characteristics were identified according to type of case. The majority of patients associated first excoriations with personal problems. Four patients reported abuse in childhood or adolescence. This study confirms that skin picking is an impulsive reaction and does not belong to the obsessive-compulsive disorders: impulsivity is defined by ineffective or failing control resulting in uninhibited behaviour. **Key words:** skin; psychogenic; excoriations; anxiety; depression; child abuse.

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Psychogenic excoriations are also called neurotic excoriations, dermatillomania or skin picking syndrome. They are not recognized in the 4<sup>th</sup> edition of Diagnostic and Statistical Manual of Mental Disorders (DSM IV) (1). However, their prevalence rate has been estimated at 2% of dermatology clinic patients (2) and was found to be 3.8% in a non-clinical sample of college psychology students (3). We believe that the prevalence of psychogenic excoriations is not as rare as previously thought.

In order to diagnose and understand psychogenic excoriations, diagnostic criteria are needed; such criteria were proposed by Arnold et al. (4).

The French Psychodermatology Group is a specialized group of the French Society of Dermatology and includes dermatologists, psychiatrists and psychologists (5). This group has previously proposed diagnostic criteria for functional itch disorder or psychogenic pruritus (6) that could be validated in other countries (7). Using the same methodology (6), we attempted to propose diagnostic criteria for psychogenic excoriations. The final decision was to adopt criteria A and B as proposed by Arnold et al. (4), but to replace criterion C (“The disturbance is not better accounted for by another mental disorder and is not due to a general medical condition.”) by 2 new criteria, as reported in Table I.

The new criterion C was proposed to exclude excoriations that could occur in somatic diseases capable of inducing pruritus (inflammatory skin diseases or others) and neurological diseases that can induce scratching (e.g. dementia). Criterion D was proposed because David Le Breton, a French sociologist, differentiates scarifications, which are self-mutilations that lack any psychological suffering and are related to a cultural context (e.g. teenage or tribal traditions), from psychogenic excoriations (8).

Psychogenic excoriations are also different from the following:

- prurigo, because prurigo lesions are secondary to scratching in response to pruritus (9, 10).
- delusional infestation, because scratching is a consequence of the fixed belief of being infested with pathogens against all medical evidence (11).
- dermatitis artefacta, because self-injury is not admitted by patients with this syndrome (12).

Table I. Diagnostic criteria of the French Psychodermatology Group for psychogenic excoriations

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A. Maladaptive skin excoriation (e.g. scratching, picking, gouging, lancing, digging, rubbing or squeezing skin) or maladaptive preoccupation with skin excoriation as indicated at least by one of the following: <ul style="list-style-type: none"><li>• preoccupation with skin excoriation and/or recurrent impulses to excoriate the skin that is/are experienced as irresistible, intrusive and/or senseless;</li><li>• recurrent excoriation of the skin resulting in noticeable skin damage.</li></ul>
B. The preoccupation, impulses or behaviours associated with skin excoriation cause marked distress, are time-consuming, significantly interfere with social or occupational activities, or result in medical problems (e.g. infections).
C. The disorder is not due to a somatic disease.
D. There is an associated psychological suffering

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- malingering, because malingering is related to the aim of obtaining material gain (12).
- special forms, such as the Gardner-Diamond syndrome, Münchhausen's syndrome and Münchhausen-by-proxy syndrome (12).

German authors have recently suggested including psychogenic excoriations with *acne excoriée*, *morsicatio buccarum*, *cheilitis factitia*, *pseudo-knuckle pads*, *onychophagia*, *onychotillomania*, *onychotemnomania*, *trichotillomania*, *trichotemnomania* and *trichoteiromania* in the definition of *dermatitis para-artefacta syndrome* (12). In these conditions, the main feature is a lack of impulse control, and thus a failure to resist the impulse or temptation repeatedly to perform an act that is harmful to the person themselves or to others, without rational motivation. The patient is partly conscious of the disorder and admits to manipulating skin, hairs or nails if queried.

In this study, we analyse the psychiatric profiles of outpatients with psychogenic excoriations and the circumstances surrounding the creation of these excoriations.

## PATIENTS AND METHODS

Outpatients presenting with psychogenic excoriations according to the diagnostic criteria of the French Psychodermatology Group (Table I) were included in the study. Dermatologists registered socio-demographic data, data from clinical examination, current treatments, medical and psychiatric history. A questionnaire with 24 questions was applied to outpatients. Questions concerned the behaviour surrounding excoriations and scratching (Table II).

## RESULTS

Ten outpatients were included in the study (9 women and 1 man; mean age 62.6 years, age range 42–80

years). None of the included outpatients had a dermatological disease or experienced pruritus.

Among the patients, 9 had a history of anxiety, 8 of depression, one of onychotillomania, one of trichotillomania, one of cancerophobia, one of hysteria and one of bulimia nervosa.

In 4 patients, picking had begun in infancy or adolescence. In the others, the behaviour was at least one year old. Eight patients associated their first excoriations with personal problems, one with diet, and one made no association.

Four patients related abuse in childhood or adolescence in answer to the question "Are there any major events in your life?". For 3 of these 4 patients, the onset of psychogenic excoriations was in childhood or adolescence. At the time of our study, they were 42, 60 and 78 years old, respectively.

All patients caused excoriations only when alone and never in front of a mirror. Three patients preferred to cause excoriations on waking, two in the evening and five at any time during the day.

All subjects were conscious of their scratching. They declared triggering factors to be fear in 6 cases, abnormal sensations in 2 cases, a need to remove bumps in one case and a need to hurt oneself in the remaining case.

Excoriated areas were always spontaneously visible (on the face and members), but 3 patients had concealed lesions. All patients used fingernails to induce lesions; additionally, one patient sometimes used a toothpick, and another used tweezers.

During scratching, 3 patients did not feel any emotion, 2 felt pleasure, 3 felt fear and 2 felt guilt. After scratching, 4 felt relief, 4 felt guilt and 2 felt pain. All patients usually used prescribed local treatments for their lesions.

Table II. *Questionnaire on excoriation-related context*

1. How old are your lesions?
2. In your opinion, what is the origin of these lesions?
3. Are you aware of your scratching?
4. When do you scratch during the day?
5. Alone or in public?
6. In front of a mirror?
7. What triggers scratching?
8. Do you have itching?
9. Where do you scratch?
10. On a visible area or not?
11. How do you scratch? With your nails? With some objects? Which ones?
12. Which are your thoughts when you scratch?
13. What do you feel when you scratch?
14. What do you feel after scratching?
15. How do you treat your excoriations?
16. Do you hide them?
17. What are the reactions of your family and friends?
18. What is your current marital status?
19. What is your current professional activity?
20. What is your level of education?
21. Are there any significant events in your life?
22. In your adulthood?
23. In your adolescence?
24. In your infancy?

## DISCUSSION

Although the data must be interpreted with caution because the study included only 10 patients, these results provide interesting data about the onset of psychogenic excoriations, the behaviour of picking, and comorbidity. Common or specific characteristics were identified according to cases. The main advantage of this study is that it is the first to be performed with precise diagnostic criteria for psychogenic excoriations.

Three other studies have been conducted previously on this disorder. Arzeno Ferrao et al. (13) compared impulsivity and compulsivity in patients with trichotillomania or skin picking with impulsivity and compulsivity in patients with obsessive-compulsive disorders (OCD). Odlaug & Grant (14) performed a semiological study. In these papers (13, 14) and in that of Mutasim & Adams (15), psychiatric comorbidity is evaluated.

The more original data manifested by our study concern the onset of psychogenic excoriations. The majority

of patients associated first excoriations with personal problems. Four patients related abuse in childhood or adolescence. In this context, skin picking appears as a gesture to remove something that is felt as dirtiness and the skin is identified with the ego, as previously described by Anzieu (16, 17). Self-injurious behaviours in young women have been reported as the consequences of childhood sexual molestation and childhood rape (18). This emphasizes the fact that dermatologists must ask patients if their skin excoriations could be related to difficult personal events and especially to (sexual or non-sexual) abuse. In our experience, asking this question often gives patients their first opportunity to speak about these events and to begin psychotherapy.

Excoriated areas were always spontaneously visible (on the face and members) but lesions could be sometimes concealed. Lesions were mainly induced by fingernails and could be inflicted at any time of the day. These results are in accordance with those of Odlaug & Grant (14), who found that some subjects could spend 6–8 h each day inducing lesions. In our study, we provide interesting data about feelings during scratching (pleasure, fear, guilt or no emotions) and after scratching (relief, guilt and pain). The messages that these patients might want to transmit through their lesions are difficult to understand because lesions, although usually visible, are inflicted when patients are alone and because patients self-treat their auto-induced lesions.

All subjects were conscious of scratching. Triggering factors were related to anxiety. Skin picking is an impulsive reaction: impulsivity is defined by an ineffective or failing control resulting in uninhibited behaviour (13). Other impulse control disorders (ICD) are pathological gambling, kleptomania, pyromania and other components (as detailed earlier in the German proposal) of the dermatitis para-artefacta syndrome (12, 13). Compulsivity is an excessive control that leads to the inhibition of a behaviour. Compulsive disorders are OCD, which were called obsessional neuroses in the past. Psychogenic excoriations were once considered an OCD (19), but studies comparing ICD and OCD show that they are distinct phenomena (13).

This explains why our study, as well as other similar studies of psychogenic excoriations (13, 15), did not find any association with OCD, but found associations with anxiety, depression and other ICD or eating disorders. Odlaug & Grant (14) found OCD prevalence to be 7–8 times greater in patients with psychogenic excoriations than in the population at large. A discussion about clinical, genetic and neurobiological differences and similarities between ICD and OCD is in progress, especially in the context of the future DSM-V. Precise diagnostic criteria, such as those we

propose in this paper, are necessary to understand these behaviours.

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