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CASE REPORT

An Interesting Case of Skin Picking in an Adolescent Girl

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ABSTRACT

Skin picking behavior described as a form of OC spectrum disorder in DSM-5. We discuss one such case in an eighteen year old girl with long standing history and how she was managed effectively with selective serotonin reuptake inhibitor and behavioral therapy.

Keywords: OC spectrum, Self-injurious behavior, Skin picking.

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INTRODUCTION

Compulsive self-injurious behavior, 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, posttraumatic stress disorder, depressive disorder, anxiety, and eating disorders.[1] Skin picking disorder (SPD) is characterized by repetitive and compulsive picking of skin leading to tissue damage. It is also known as pathological SP, dermatillomania, or "neurotic excoriation."[2]

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 disorder (OCD). The prevalence of SPD has been found to be 1.25 to 5.4% among the general population and 11.8% of adolescent psychiatric inpatients.[3] Here we report a case of chronic SPD in an adolescent girl.

CASE REPORT

An 18-year-old Hindu, unmarried girl from a rural background was brought to our outpatient department with complaints of excessive skin scratching and SP of the right hand fingers and toes for last 8 years with history of exacerbation on and off. Her SP behavior was a daily routine and was associated with anxiety symptoms, followed by feeling of relief after picking. She was treated by a general practitioner and dermatologist for the same for the last 2 years. None of the therapies provided adequate relief of symptoms. She had stopped going to family functions, had difficulty in concentrating in her study, and did not feel like interacting with others. There were no other complaints like persistent sadness of mood, ideas of helplessness and worthlessness, hearing unseen voices, muttering to self and gesticulating behavior. There was no sleep or appetite disturbance. There was no history of psychiatric illness in the family. She did not suffer from any other medical or surgical illness. No significant abnormalities were noted on general and systemic examinations apart from skin lesions on fingers of hands, toes, and feet. On mental status examination (MSE), she was constantly fidgeting with her fingers. Eye-to-eye contact was initiated but not maintained. She conveyed that she did not feel at peace and her affect was anxious. No other abnormalities were found on MSE. She was diagnosed as having excoriation (SP) disorder as per DSM-5. She was started on cap Fluoxetine 20 mg in the morning after breakfast and Topiramate 25 mg half tablet twice a day. On subsequent follow-up, the dose of Topiramate was increased to 50 mg twice a day. Behavior therapy was also used. Gradual improvement was noted. She had reduced anxiety and decreased the time she spent in picking the skin.

DISCUSSION

Skin picking disorder has been historically classified as an impulse-control disorder not otherwise specified, a stereotypic movement disorder,[4] an OCD,[5] a behavioral addiction,[6] and a form of self-injurious behavior.[7] The DSM-5 has included it separately in the chapter of OCD and related disorders.[8]

The SPD is characterized by recurrent picking of one's skin. Skin is most commonly picked from the face, arms, and hands but individuals may pick, squeeze, or rub a range of areas, targeting healthy skin, minor skin irregularities, or scabs. Some individuals describe an urge to pick, which is relieved by SP, some doing it automatically without full awareness.[9] It was first described by Erasmus in 1875.[10]

Odlaug and Grant[5] suggested that excoriation disorder is more similar to substance abuse disorder than OCD. They argued that as compared with OCD, excoriation disorder may be inherently pleasurable and the treatments that are

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generally effective for patients with OCD (i.e., selective serotonin reuptake inhibitors and exposure therapy) may not be as successful in patients with excoriation disorder. Unlike OCD, picking the skin is rarely driven by obsessive thoughts. Odlaug and Grant[5] have recognized the following similarities between SP and substance abuse, i.e., a compulsion to engage in the negative behavior despite knowledge of the harm, a lack of control over the problematic behavior, and a strong urge to engage in the behavior prior to engagement with a feeling of pleasure while engaging in the behavior or a feeling of relief or reduced anxiety after engaging in the behavior.

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