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Excoriation Disorder

Karalynn Johnson
University of North Dakota, karalynn.johnson@und.eduu

EXCORIATION DISORDER

by

Karalynn Johnson

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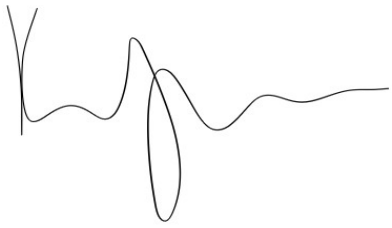
Signature _ 

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Abstract

S.W. is a 17-year-old female with a history of depression and anxiety. She has previously had suicidal thoughts but no history of suicide attempts. She has anxiety about school and being around large groups of people. She has been taking citalopram and has noticed a significant decrease in her anxiety and depressive symptoms. Her mother noticed she was picking at her scalp which was causing lesions. She was seen by dermatology and they ruled out a physical cause. She was given a diagnosis of excoriation disorder. An overview of the literature supports using N-Acetylcysteine, SSRIs and cognitive behavioral therapy as treatments for excoriation disorder. S.W. is already taking an SSRI medication. The plan of care for S.W. is to start N-Acetylcysteine and follow up in a month to see how she responds to treatment. Excoriation disorder is a relatively new disorder and it will be important for providers to keep up on research as treatment methods continue to be studied.

Keywords: Excoriation disorder, skin picking disorder, treatments

Excoriation disorder

Background

Excoriation disorder, also known as skin picking disorder, is characterized by repeated manipulation or picking of skin that causes damage to the tissue (Anderson & Clarke, 2019). Body-focused repetitive behaviors (BFRB) are compulsive acts that can cause harm and affect physical appearance. These behaviors are problematic when they cause difficulty in functioning in personal, social, work and other situations (Nwankwo & Jafferany, 2019). Excoriation disorder a relatively new diagnosis added under the obsessive-compulsive disorders in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders. The diagnostic criteria for excoriation disorder includes repeated picking at skin that results in lesions, attempts to stop picking, clinically significant impairment in functioning in at least one area such as social or occupational, picking is not due to a physical cause or substance and is not better explain by another mental health disorder (American Psychiatric Association, 2013). Individuals who have skin picking behavior should be evaluated to determine if there is a dermatological cause for the behavior (Jones, Keuthen & Greenberg, 2018).

Prevalence rates for excoriation disorder range from 1.4% to 5.4% of the population (Anderson & Clarke, 2019). This disorder is more common in women than in men at a ratio of 8:1 and has an average age of onset ranging from 15 to 45 years old (Turner, Sutton & Sharma, 2014). There is a high rate of comorbid mental health disorders. Mood disorders including major depression, bipolar or dysthymia are present in 48% to 68% of individuals with this disorder. Anxiety disorders, such as generalized anxiety, panic, posttraumatic stress disorder, social phobia, specific phobias, agoraphobia or obsessive-compulsive disorders are present in 41% to 65% of individuals with excoriation disorder (Turner, Sutton & Sharma, 2014).

Individuals can pick at any area of the skin but most commonly the areas affected are the face, arms, scalp and legs (Anderson & Clarke, 2019). The majority of people with this disorder pick at their skin unconsciously and are not aware that they are doing it. Some people will pick at their skin as a conscious response to external factors, such as anxiety or boredom (Anderson & Clarke, 2019).

Excoriation disorder has an effect on individuals both physically and psychosocially. There is physical damage to the skin which results in lesions, bleeding, infections and scaring of the tissue. For some individuals the damage can be so extensive that it will require antibiotics or surgery to correct it. There are significant psychosocial affects as well. Many people avoid social situations and events or try to conceal their skin to hide any lesions that might be showing. Some individuals will also avoid intimate relationships to prevent revealing their lesions and scars to others. Shame is also experienced by this population. Many people do not seek treatment for long periods of time due to shame and being embarrassed by the fact that the lesions are self-inflicted (Anderson & Clarke, 2019).

Case Report

S.W. is a 17-year-old female who was initially assessed for complaints of depressed mood and anxiety. She was having low motivation, low self-esteem and depressed mood for three years. She was having suicidal thoughts at times with no plan or intent to act on them. She has no history of a previous suicide attempt. She was also experiencing anxiety. She worries about fast paced environments and social situations that have more than a few people. She was feeling overwhelmed by school and her anxiety was keeping her from spending time with friends. She was having panic attacks that would include increased heart rate, chest tightening, shortness of breath, sweating, nausea and a feeling of “wanting to flee to a quiet space.” She was

having almost daily headaches that she related to increased anxiety. She has a history of attention deficit or hyperactivity disorder but currently does not take medications for this. She feels she is able to concentrate and get the work done at school. She denies any past psychiatric hospitalizations. She denies any medical diagnoses.

S.W. has a family history that is significant for her mother having depression. Her mother has had low moods that are affected by her thyroid function. The patient's thyroid stimulating hormone was tested and found to be within normal limits. Her father has an anxiety disorder. No other family history of mental illness.

She lives with her mother, father and younger brother. She feels her family is very supportive. She denies any history of physical, sexual or emotional abuse. She is a senior in high school. She does not enjoy school and is taking some easy classes this last year of school to do a "senior slide" until graduation. S.W. is working at the pizza ranch. This is her first job. She says it is stressful when it is busy but overall, she likes the job. She enjoys listening to music. Her stated strengths are "I am good at drawing and singing."

After starting on Celexa and titrating up to 40 mg S.W. felt her anxiety and depression are under much better control. Her mother noticed that she had been picking at her skin, causing scabs to form on her scalp and other areas of her face. S.W. often did not realize when she was picking at her skin. She was worked up by a dermatologist who gave her a few different treatments, including medicated shampoo and creams and yet she continued to pick at her scalp. A biopsy was obtained of an area she was picking at and resulted in no infections or physical reasons for picking. She is working with a therapist on building her self-worth as she has poor self-esteem.

Literature Review

Treatment for excoriation disorder includes nonpharmacological and pharmacological options. N-acetylcysteine has been studied for its effects in other obsessive-compulsive disorders and found to be useful in reducing symptoms. In a study at the University of Minnesota and University of Chicago, participants with excoriation disorder were randomly assigned to treatment groups with N-acetylcysteine or a placebo. Forty-seven percent of the participants in the group treated with N-acetylcysteine were much or very much improved verses 19% in the placebo group. The participants noticed they had less of an urge to pick at their skin (Grant et al., 2.16). Another study of patients with excoriation disorder and Prader Willi syndrome found that 71% of participants had no further skin picking (Nwankwo & Jafferany, 2019).

Selective serotonin reuptake inhibitors (SSRIs) have been studied for this disorder. In one study, Fluoxetine improved symptoms in one of three outcomes that was measured. In a second participants had a 53.3% response rate. Half of respondents were placed in a continued fluoxetine group and the other half were put in a discontinuation group. Those in the continued fluoxetine group maintained their improvements in skin picking while the discontinuation group returned to their baseline level of severity (Lochner, Roos & Stein, 2017). Citalopram was studied in a group of 45 people. Scores on the Yale-Brown Obsessive-Compulsive Scale were significantly decreased in the treatment group versus placebo. In a study of escitalopram, 44.8% of participants completely stopped skin picking and an additional 27.6% showed a partial decrease in skin picking. Sertraline has shown a response rate of 68%. A study of 14 people given fluvoxamine resulted in less picking at skin, healed abrasions and an improvement in the presence of skin sensations (Lochner, Roos & Stein, 2017).

The use of lamotrigine was studied in two separate trials. In an open trial response rates were 67% to treatment and in a controlled trial response rate was 43.8% (Selles, McGuire, Small

& Storch, 2016). More research is needed to support efficacy for treatment of excoriation disorder with this medication. There have been cases where SSRIs have been augmented with antipsychotics, such as olanzapine or paliperidone, which have resulted in decreased skin picking (Lochner, Roos & Stein, 2017).

A case study reviewed the use of venlafaxine along with aripiprazole in a patient who had a treatment resistant case of excoriation disorder. During a hospitalization she was trialed on quetiapine and mirtazapine to try to help alleviate anxiety and skin picking symptoms. This was not beneficial. She was prescribed 10 mg of aripiprazole at bedtime. She felt a significant decrease within 48 hours to skin pick. She was observed to have no new lesions and old lesions healed. At three weeks out she continued to state she had no return of symptoms. The dopaminergic pathway has been implicated in excoriation disorder, which makes the class of antipsychotics a viable treatment option. This is only one patient report and needs further study but it shows a hopeful treatment strategy for excoriation disorder (Turner, Sutton & Sharma, 2014).

Cognitive behavioral therapy (CBT) focuses on education, restructuring thoughts and preventing relapse by helping patients increase their self-efficacy (Lochner, Roos & Stein, 2017). Habit reversal therapy (HRT) is one type of CBT. There are two elements to this training. One is awareness training that helps patients become aware of their habits and monitor them. The second element is competing response training that replaces skin picking with another response, such as making a fist (Lochner, Roos & Stein, 2017). Skin picking has been described as a body-focused habit. Habits are also known as stimulus response behaviors. They are a fixed response that is learned over time as an automatic response to a trigger. Habit reversal includes multiple behavioral components that help patients to change their habits, including keeping a record,

increased awareness through training, competing response practice, motivation for habit control and other generalized training. A review of two individual random control trials showed improvements in patients by decreased skin picking with HRT. One study showed a decrease in skin picking for both the control and treatment group, but only the treatment group showed significant improvement in pre and post treatment photos. In a second study, the habit reversal therapy group showed significant improvement on the Modified 10-item Skin Picking Scale versus the control group (Lee, Mpavaenda & Fineberg, 2019).

Another type of CBT is acceptance and commitment therapy (ACT). This type of therapy works to help patients accept that there will be negative thoughts and feelings as part of the normal experience of humans. Then it helps them think of ways to act on the negative thoughts and feelings in a way that is in line with their life values and goals they have set. The goals are specific to the type of picking the patient does, such as not picking at the scalp or fingernails. In a small study on ACT, four of five participants using this therapy completely stopped picking at their skin, although in follow up meetings only one of the participants maintained this improvement (Lochner, Roos & Stein, 2017).

Acceptance-enhanced behavior therapy (AEBT) combines HRT with ACT. A review of two patients with excoriation disorder showed that when started with HRT in the early phase of treatment and later integrated ACT skills they picked less often at their skin (Capriotti, Ely, Snorrason & Woods, 2015). A review of four case studies using AEBT found that patients had a decrease in severity of picking with this therapy. Three of the four patients had great response to treatment and the other showed a pattern of relapsing and remitting (Capriotti, Ely, Snorrason & Woods, 2015).

Save My Skin is a website that was developed for people with excoriation disorder to seek self-help with an online forum. It is a twelve-week program that is based in cognitive behavioral therapy. It includes education on excoriation disorder, exercises to practice, a supportive monitoring program and access to a dermatologist or counselor via chat (Gallinat et al., 2019a). In the current study they had two groups, intervention and a waitlist group. It was found that the intervention group had large improvements in the severity score for skin picking over the waitlist group. This study shows an online forum can be useful to reach this patient population for treatment options (Gallinat et al., 2019a).

Aydin et al. (2019) explored the use of repetitive transcranial magnetic stimulation (rTMS) for patients with excoriation disorder. Previous studies have shown that rTMS over the supplementary motor area produces positive results in individuals with obsessive compulsive disorders. This study excluded participants with comorbid disorders that included dementia, bipolar disorder, psychotic disorders, substance abuse in the last month, high suicide risk, several neurological disorders, any metal implants, pregnancy or a score higher than 16 on the Beck Depression Inventory. Fifteen participants were divided into the treatment and sham groups. The treatment group had a response in 62.5% of participants whereas the sham group had a response rate of 33.3%. The treatment group had reduced severity of their symptoms of excoriation disorder but the results were not statistically significant. Future studies need larger sample sizes to evaluate the efficacy of treatment. Further neuroimaging studies of individuals with excoriation disorder could also show other target areas for rTMS (Aydin et al., 2019).

Biofeedback is another treatment strategy that has been studied for excoriation disorder. The purpose of biofeedback is to help patients inhibit excessive physiological impulses and reinforce impaired physiological impulses. This can help patients identify and learn to manage

their specific symptoms. In a meta-analysis that reviewed biofeedback in patients with obsessive compulsive disorder and related disorders, Ferreira, Pêgo & Morgado, (2019) reviewed five studies that used neurofeedback in individuals with obsessive compulsive disorder. The results show that patients had a positive effect from the treatment but there were many limitations to the studies, including poor methodology and reporting bias. It is hypothesized that since biofeedback has been beneficial in OCD it could be helpful in related disorders, such as excoriation disorder (Ferreira, Pêgo & Morgado, 2019). OCD and related disorders share similar characteristics of compulsive behaviors, impaired inhibition of behaviors, similar characteristics such as family patterns and comorbidities, neurotransmitter imbalances and similar treatment response. Further studies are needed to confirm the usefulness of biofeedback in excoriation disorder.

Implications

Psychiatric/mental health nurse practitioners (PMHNPs) have an opportunity to help individuals who may feel there is no hope or treatment options. A thorough assessment of history and symptoms is important to make an accurate diagnosis of excoriation disorder. Education will be necessary as some patients may not recognize their skin picking as a mental health disorder. Increased awareness of excoriation disorder in medical settings is also necessary as patients do not have a high expectation that family doctors or dermatologists can be helpful to their situation (Gallinat et al., 2019b). Excoriation disorder is fairly common in the population and there is a need for increased awareness and understanding for treatment through an interdisciplinary approach (Jafferany & Patel, 2019).

Several interventions have been studied and found to be effective for excoriation disorder. N-Acetylcysteine, SSRIs and CBT, specifically HRT have been the most effective

treatments studied (Jafferany & Patel, 2019). The PMHNP should offer education on options that are available and work with patients to develop treatment goals based on the patient's preference.

This is a more recent disorder and the PMHNP needs to stay current on research as it is developed. Future research studies should evaluate multiple treatment approaches within the same study to compare outcomes based on the different treatment options. When the opportunity arises, patients should be informed of research studies they may be eligible to participate in.

Conclusion

Excoriation disorder is characterized by picking at the skin until lesions are formed. Many patients may not recognize this as a mental health disorder. PMHNPs should approach treatment in a holistic manner and consider pharmacological and therapeutic approaches based on the preferences of the patient.

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