

Near-fatal Skin-picking Due to Obsessive Compulsive Disorder Responding to Combined Fluoxetine and Cognitive-behavioral Therapy: A Case Report

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ABSTRACT:

Near-fatal skin-picking due to obsessive compulsive disorder responding to combined fluoxetine and cognitive-behavioral therapy: A case report

Pathological skin-picking has been reported to be associated with major psychiatric disorders. The most common comorbid psychiatric diseases found in patients with skin-picking were major depression and anxiety disorders (especially obsessive-compulsive disorder). Skin-picking may also lead to medical complications. We describe a 40-year-old, married woman with compulsive skin-picking who developed the dangerously self-destructive habit of squeezing or digging debris out of skin tissue and picking at acne and scabs on her forehead, cheeks and chin. The patient was successfully treated with a combination of fluoxetine and cognitive-behavioral psychotherapy.

Key words: skin-picking, obsessive-compulsive disorder, fluoxetine, cognitive-behavioral therapy

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INTRODUCTION

Skin-picking is a nearly universal behavior in mammals. Pathological skin-picking, however, can be a chronic severe condition in some individuals associated with numerous medical (1) and psychiatric disorders (2,3). The psychosocial consequences of this problem have increasingly received recognition. Despite its potentially severe health impact, a general under-appreciation exists for the phenomenological complexity of skin-picking as well as the resulting implications for etiology, assessment, and treatment (4,5,6,7,8).

Efforts to reliably and meaningfully classify skin-picking have been the subject of considerable debate (4). Pathological skin-picking has been conceptualized as an obsessive-

compulsive spectrum disorder (along with trichotillomania and nail-biting), as a self-mutilating behavior and as an impulse-control disorder (5). Also, depressive disorder, anxiety disorder and hypochondriasis are the leading axis I psychiatric disorders considered to be associated with skin-picking (6,7). Pathological skin-picking generally has serious potential health consequences. It should not be underestimated as a cause of medical problems with the potential to complicate the treatment effort (8). The behavior in pathological skin-picking sometimes resembles obsessive-compulsive disorder in that it is repetitive, ritualistic, and tension reducing. The patients attempt to resist skin-picking but fail. Case reports and open trials demonstrate the responsiveness of compulsive skin-picking to treatment with serotonin reuptake inhibitors (9). There are also case reports of successful treatment of

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skin-picking with behavioral therapy (10).

We describe the case of an individual with compulsive skin-picking who had developed the self-destructive habit of squeezing or digging debris out of skin tissue. The patient was successfully treated with combined fluoxetine and cognitive-behavioral therapy.

CASE HISTORY

A 40-year-old, married woman with two children was found to pick at acne and scabs on her forehead, cheeks and chin. This picking was done using tweezers and pins and was occurring compulsively. Bleeding, minor sores and scars, as well as social embarrassment, guilt and avoidance resulted from the picking. Pre-picking tension buildup was reported, but post-picking relief, pleasure, or gratification was not. The patient was complaining of lack of interest in life and feelings of meaninglessness. She was eventually admitted to the psychiatric inpatient unit for a further evaluation. Her psychiatric history showed that twenty years ago, she had been engaging in excessive house-cleaning in order to suppress the thought that the house was dirty. On occasion, she had even gone to the extreme of using a ruler when replacing the rugs. At that time, she had engaged in mild acne-picking but there had been no skin damage. Ten years ago, after skin-picking behavior had led to some facial damage and disfigurement, she was hospitalized on a number of occasions and treated with drugs such as clomipramine, fluoxetine, paroxetine, and bupiron. She had been treated with clomipramine (maximum dosage 150 mg/day), fluoxetine (60 mg/day), paroxetine (40 mg/day) and bupiron (30 mg/day) in combination irregularly for about six months. More detailed information was not kept regarding the treatment. On the other hand, she had received no psychological support and psychotherapy at that time. She indicated that there had been some positive outcome only with fluoxetine use, although she still engaged in skin-picking.

Six months ago she sought emergency medical care due to serious bleeding from skin-picking. After a surgical intervention and a short stay in a psychiatric unit, she was discharged. The skin-picking behavior and subsequent bleeding were repeated many times and

caused re-admissions to the emergency room and repeated surgical interventions. She opened the sutures immediately following discharge and caused the wounds to resume bleeding by digging at the tissue. In addition, she finally admitted to her family that she had tried to commit suicide by overdose and was brought in to our hospital. A physical examination was conducted and it was determined that she had multiple lesions (older scars and new ones) on her forehead, cheeks and chin, 1-3 cm in length and 0.5 cm in depth.

Depression, anxiety, and obsessions-compulsions were rated using the Hamilton Rating Scale for Depression (11) (HAM-D17), the Hamilton Rating Scale for Anxiety (12) (HAM-A), and the Yale-Brown Obsessive Compulsive Scale (13) (Y-BOCS) in the first evaluation and follow-ups at three and six weeks. The scores for HAM-D, HAM-A, and Y-BOCS were 30, 27, and 57, respectively, in the first evaluation. In the Rorschach Projective Test, she was found to be suffering from anxiety and to be in a depressive state.

She was diagnosed with obsessive-compulsive disorder and major depressive disorder according to DSM-IV diagnostic criteria (14). She had no history of developmental abnormalities. Her family history was unremarkable. The drug of choice was fluoxetine due to a previous partial response. Fluoxetine, at 20 mg/day was started and increased to 40 mg/day over the first two weeks and increased to 60 mg/day over the following three weeks. At the end of three weeks, the scores for HAM-D, HAM-A, and Y-BOCS were 20, 18, and 35, respectively. At the end of six weeks, the compulsive skin-picking behavior had disappeared and the scores for HAM-D, HAM-A, and Y-BOCS were 6, 8, and 9, respectively. The patient was also given cognitive behavioral therapy during her hospitalization. A variety of techniques such as anxiety management training, habit reversal, individual therapy and group psychotherapy were used. Following the assessment, the first individual therapy session was dedicated to educating the patient about the relationship between obsessive-compulsive disorder and skin-picking. The other 9 sessions were dedicated to mapping the disorder, that is, describing specific obsessions, compulsions, triggers, avoidance behaviors, and consequences. Anxiety management training included relaxation and diaphragmatic

breathing techniques. Habit reversal training was included and consisted of self monitoring, recording episodes of scratching, and procedures producing alternative responses to scratching. The patient attended the group sessions during the hospitalization every day. She was hospitalized for six weeks and then discharged from the hospital. The patient continued the same medical treatment for ten months, and her prognosis remains positive.

DISCUSSION

There is an increasing awareness that skin-picking may, in certain cases, amount to a mental disorder. This paper summarizes the findings in previous studies and hypothesizes skin-picking to be part of the obsessive-compulsive spectrum disorder. Pathological skin-picking begins as an urge to touch, scratch, squeeze, or dig at the skin, often in response to acne or a minor flaw. Tools, such as pins and tweezers, are often used, and skin damage can range from mild to extreme. The behavior often leads to disfigurement, shame, and social impairment (4).

Although the epidemiology of pathological skin-picking has not been studied in the general population, pathological skin-picking is estimated to occur in 2% of dermatology clinic patients. It seems to be more prevalent in women than in men, often starts in adolescence, and takes a chronic course (10). It was found that demographic variables, clinical comorbidity, and personality dimensions showed considerable overlap between trichotillomania and pathological skin-picking. Both trichotillomania and pathological skin-picking have been described as having both compulsive and impulsive features (15). Trichotillomania is classified as an impulse control disorder, but pathological skin-picking is not formally recognized in DSM-IV (14) and has no widely accepted diagnostic definition. The phenomenology and comorbidity have been described in one series of modest size (16).

Psychiatric comorbidity in patients with skin-

picking, particularly mood and anxiety disorders, is common. Patients with skin-picking frequently have comorbid disorders in the compulsivity-impulsivity spectrum, including obsessive-compulsive disorder, body dysmorphic disorder, substance use disorders, eating disorders, trichotillomania, kleptomania, compulsive buying, obsessive-compulsive personality disorder, and borderline personality disorder (10). We suggest that compulsive skin-picking may be a variant of OCD and we also consider the primary diagnosis to be in the same category. Wilhelm et al (16), found that the most common comorbid Axis I diagnosis was obsessive-compulsive disorder (52%). It was suggested that self-injurious skin-picking may be conceptualized as a variant of OCD or impulse-control disorder with self-injurious features. However, skin-picking may be accompanied by organic diseases. Strickland et al. reported that clinicians should consider several possible organic causes as anaemia, uremia, hepatic disease in skin-picking. Clinicians should choose the appropriate treatment option, depending on the skin-picking mechanism identified (17).

Various studies suggest that selective serotonin reuptake inhibitors (SSRIs) may be useful in treating pathological skin-picking (5). Improvement in skin-picking behaviors appeared to be independent of changes in depression and anxiety (9). We suggest that our patient was a partial responder to the SSRIs treatment. No explanation of what factors could result in resistant cases could be found in the literature. A combined fluoxetine and cognitive-behavioral therapy was used and a good response to the treatment was observed. Another interesting point was that while skin-picking had no delusional element, it can have potentially severe physical consequences for the patient. Skin-picking may be related to co-morbid major depressive disorder.

In conclusion, compulsive skin-picking may be conceptualized as one of the signs in the obsessive-compulsive spectrum disorder, rather than be included in the spectrum as a separate disorder.

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