Journal of Obsessive-Compulsive and Related Disorders 2 (2013) 167–175

Contents lists available at SciVerse ScienceDirect

Journal of Obsessive-Compulsive and Related Disorders

journal homepage: www.elsevier.com/locate/jocrd

Pharmacological and psychological treatments of pathological skin-picking: A preliminary meta-analysis

Bethany L. Gelinas *, Michelle M. Gagnon

Department of Psychology, University of Regina, 3737 Wascana Parkway, Regina, SK, Canada S4S 0A2

ARTICLE INFO

Article history:
Received 12 October 2012
Received in revised form
2 February 2013
Accepted 8 February 2013
Available online 16 February 2013

Keywords:
Pathological skin-picking
Efficacy
Treatments
Meta-analysis
Obsessive–compulsive related disorders

ABSTRACT

Extant literature has suggested that both pharmacological and psychological approaches are efficacious treatments for pathological skin-picking (PSP); however, their relative effectiveness has not yet been examined. Furthermore, case studies are the most prevalent form of PSP treatment research, necessitating a review of the available systematic research in this area. The current meta-analysis indicates that both approaches are comparably effective in reducing PSP severity. An additional examination of pharmacological effects on secondary symptoms revealed that pharmacological interventions are useful in reducing obsessive–compulsive symptoms, but have little effect on comorbid anxiety and depression symptoms. Future research should consider more rigorous methods of treatment studies, potentially increasing treatment efficacy by combining pharmacological and psychological approaches, and taking secondary symptomatology into account. Examining the comparative effectiveness of these approaches serves to guide and inform practitioners, and thus provide patients with the best standard of care.

Contents

* Corresponding author. Tel.: +1 3063373339.
E-mail address: gelinabe@uregina.ca (B.L. Gelinas).

2211-3649/$ - see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.jocrd.2013.02.003

1. Introduction

Pathological Skin-Picking (PSP) has been defined as recurrent skin-picking accompanied by visual tissue damage resulting in significant distress and/or functional impairment. This disorder, also referred to as psychogenic excoriation, neurotic excoriation, acne excoriée, and dermatillomania, is characterized by excessive scratching, picking, gouging, digging, rubbing or squeezing of normal skin, or skin with minor irregularities (Arnold, Auchenbach, & McElroy, 2001). Excoriations are typically found in areas that are easily reachable, with the face being the most common site (Flessner & Woods, 2006).

Prevalence of PSP is largely unknown; however, a recent national telephone survey of 2513 adults assessed lifetime prevalence of PSP in the United States (Keuthen, Koran, Aboujaoude, Large, & Serpe, 2010). Skin-picking resulting in some damage was experienced by 16.6% of respondents; however only .2% of the sample met strict criteria for PSP. Less strict diagnostic criteria (in which respondents had to experience either distress or impairment, but not both) resulted in a prevalence estimate of 1.4%. Other prevalence estimates of PSP include 2% of all dermatology patients (Arnold et al., 2001), and approximately 4% of university students (Keuthen et al., 2000). Many researchers assert that rates of PSP are underestimated, as skin-picking is an underreported behavior, and those with PSP are disinclined to seek treatment (Neziroglu, Rabinowitz, Breytman, & Jacofsky, 2008).

The duration of skin-picking episodes can range from 5 min to 12 h per day (Arnold et al. 1998; Flessner & Woods, 2006; Odlaug & Grant, 2008). PSP is more common in females, and has a bimodal age of onset, occurring in late childhood and early adolescence, or alternatively between the ages of 30 and 45 (Arnold et al., 1998; Bohne, Keuthen, & Wilhelm, 2005; Keuthen et al., 2000; Odlaug & Grant, 2007). Research suggests that the mean duration of symptoms ranges between 5 and 21 years, although the behavior waxes and wanes throughout this period (Arnold et al., 1998; Flessner & Woods, 2006; Simeon et al. 1997).

PSP often results in substantial distress, involving embarrassment or shame about the behavior, dissatisfaction with appearance, and difficulty confiding in health professionals or friends and family members (Simeon et al., 1997). Medical complications such as sores, scarring, and occasionally infections and disfigurement can also result (Keuthen et al., 2000; Neziroglu et al., 2008). Impairment in academic and occupational functioning has also been noted (Flessner & Woods, 2006). Impairment in social functioning is also common, as individuals with PSP report avoidance or restriction of social or sexual activities, social withdrawal, and occasionally confinement to their houses (Simeon et al., 1997).

2. Relationship to obsessive–compulsive and related disorders

PSP is not currently classified as a separate disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000); instead it is considered an impulse control disorder not otherwise specified. In the past, PSP has been classified under various diagnostic categories, including stereotypic movement disorders, body dysmorphic disorder, and obsessive–compulsive spectrum disorders (Calikuşu & Tecer, 2010). These alternative classifications may be considered because of the high comorbidity between PSP and the disorders from these categories. One of the new clinical diagnoses proposed for inclusion in the fifth edition of the DSM (DSM-5; American Psychiatric Association, 2011a) is Skin-Picking Disorder. This new term for PSP has been recommended for inclusion as an obsessive–compulsive and related disorder (OCRD; American Psychiatric Association, 2011b).

Psychiatric comorbidity is common in individuals with PSP. In fact, one of the arguments as to why PSP should be considered an OCRD is due to the findings that a significantly higher rate of obsessive–compulsive disorder (OCD) has been reported among individuals with PSP than among control samples (Calikuşu, Yusel, Polat, & Baykal, 2003). Furthermore, elevated rates of PSP have been reported among OCD patients and their first-degree relatives (Cullen et al., 2001). A comorbid diagnosis of OCD among PSP patients has been as high as 45%–68% (Calikuşu et al., 2003; Neziroglu et al., 2008). Comorbidity with other OCRDs is also high. Trichotillomania, another disorder being considered as an OCRD in the DSM-5, is comorbid with PSP at rates estimated between 6% and 36% (Arnold et al., 1998; Arzeno Ferrao, Almeida, Bedin, Rosa, & D'Arrigo Busnello, 2006; Odlaug & Grant, 2007; Simeon et al., 1997; Wilhelm et al., 1999). Similarly, studies have found that 27%–50% of individuals with body dysmorphic disorder engage in skin-picking behaviors (Grant, Menard, & Philips, 2006; Phillips & Taub, 1995). Arnold et al. (1998) reported that approximately one-third of their PSP participants suffered from body dysmorphic disorder with a specific preoccupation with skin appearance. Apart from OCRDs, mood and anxiety disorders have a disconcertingly high comorbidity with PSP. Current mood disorders are found in 48%–68% of individuals, and current anxiety disorders are found in 41%–65% (Arnold et al., 1998; Arnold et al., 2001). Skin-picking severity has been demonstrated to be associated with depression and anxiety scores (Flessner & Woods, 2006); therefore, those individuals without a diagnosable mood or anxiety disorder are likely still experiencing distressing symptomatology.

3. Treatment approaches

Extant literature has suggested two approaches, pharmacological and psychological, to the treatment of PSP. Pharmacotherapy treatments for PSP have spanned a number of classes of medication. Although pharmacotherapy treatments have focused on antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs), antiepileptics, opiate antagonists, and atypical antipsychotics have also been used. Various open-label and controlled trials of antidepressants have examined fluoxetine (Bloch, Elliott, Thompson, & Koran, 2001; Simeon et al., 1997), escitalopram (Keuthen et al., 2007), sertraline (Kalivas, Kalivas, Gilman, & Hayden, 1996), and fluoxamine (Arnold et al., 1999), while case reports have examined the use of paroxetine, doxepin, and clomipramine (Arnold et al., 2001). The antiepileptic lamotrigine has been examined in both open-label and controlled trials (Grant, Odlaug, & Kim, 2007; Grant,