Picking Apart the Picker: A Clinician's Guide for Management of the Patient Presenting With Excoriations

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Management of patients who "pick" at their skin is often difficult. Etiologies and maintaining factors can be unclear. Significant psychiatric overlay is often present, and the clinician is left with an overwhelming differential diagnosis and a poorly focused treatment plan that can result in suboptimal clinical outcomes. The purpose of this paper is to provide a conceptual framework for the evaluation and treatment of patients presenting with excoriations. Ten diagnostic categories are examined, and specific suggestions for treatment are offered.

All people manipulate their skin. We touch, rub, squeeze, scratch, and pick. Skin manipulation can be initiated or maintained due to cutaneous lesions or imperfections or may occur in response to altered sensations in the skin. However, manipulation often occurs in the absence of visual or tactile stimuli. Clinically relevant manipulation (picking) is characterized by disfiguring insult to the integument or by social, vocational, or intrapsychic morbidity (dysfunction) caused or worsened by skin excoriation. Picked or excoriated skin is a common clinical presentation observed by the dermatologic, general medicine, and psychiatric practitioner. If well-recognized organic etiologies have been ruled out, patients are often overtly or covertly diagnosed as "neurotic excoriators" or "crazy pickers and scratchers." Lack of a precise diagnosis inevitably leads to both abandonment of scientific rigor and poorly focused patient management.[1,2] Phillips and Taub[3] have stated that the term *neurotic excoriations*, "while useful in underscoring the behavior's psychiatric etiology, is a broad term used since 1875 that does not specify the underlying psychiatric disorder or have clear treatment implications." Not all picking is motivated by the same underlying factors. Phillips[4] has suggested that skin picking can be a manifestation of body dysmorphic disorder (BDD), while others have suggested that it may be related to obsessive-compulsive disorder (OCD).[5,6] Regardless of the underlying etiology, skin picking is common. Keuthen et al[7] found that 78% of a nonclinical sampling of college students admitted to some degree of skin picking. Further, 48% of the pickers reported noticeable skin damage.[7] Thus, we propose that skin picking is ubiquitous and that precise treatment algorithms are essential for effective patient management.

Our goal is to provide a more useful conceptualization and classification of patients presenting with excoriations. The authors assume that traditional management strategies—such as occlusion, topical corticosteroids, mentholated compounds, tar preparations, emollients, intralesional corticosteroids, and cryosurgery—have been and will continue to be employed along with our psychocutaneous recommendations. Patients who pick their skin can be thought of as belonging to one of the 10 general groups of pickers we describe (Table 1).

General Considerations

When symptoms of anxiety, depression, OCD, or psychosis are clinically evident, augmentation of

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traditional dermatologic treatments with psychotherapeutic techniques and selected antidepressant, anxiolytic, and antipsychotic medications can greatly enhance therapeutic outcomes (Table 2). Traditional dermatologic therapies, including topical and oral agents, occlusion, casting, and, in extreme cases, hospitalization, remain the mainstay of treatment. Psychiatric referral is often not possible because of patient resistance and insurance constraints. Thus, it is incumbent upon the dermatologist or primary care physician to provide appropriate treatment. When evaluating an anxious or depressed patient, the risk of suicide must always be considered and assessed. Appropriate psychiatric referral is mandatory if there is overt or implied suicidal intent. The severity of excoriations and psychosocial impairment can be an indicator of the risk to the patient or others and of the urgency for treatment. When psychiatric referral is necessary, it is often best to tell patients that the referral is to a "skin emotion specialist" who understands the unique skin-emotion link. This euphemism is usually better accepted than traditional referral to a "shrink."

Table 2 lists various emotional states and the suggested psychotropic agents for their management. In general, treatment should be initiated at a low dosage unless the patient is severely agitated or suicidally depressed (reasons for immediate psychiatric referral). This approach often can minimize unpleasant side effects that can lead to noncompliance. Dosing regimens should be titrated up at 2- to 3-week intervals until the desired therapeutic effect is achieved.[8]

Both recognized and idiosyncratic side effects are always possible. Thus, it is suggested that clinicians become familiar with one or two agents in each therapeutic class and begin incorporating those agents into their practice. Clinicians who are uneasy with the concept of prescribing psychotropic agents must recall that the American Academy of Dermatology Task Force on Psychocutaneous Medicine endorses these medications and encourages their use.

Table 1.

Categories of Pickers

Categories of Pickers
Angry
Anxious/depressed
Body dysmorphic
Borderline
Delusional
Guilty
Habit
Narcissistic
Obsessive compulsive
Organic

The Angry Picker

Picking can be a manifestation of conscious or subconscious anger. The individual may "choose" to pick as an attempt to sublimate rageful or unacceptable impulses. Angry pickers can be passive and nonassertive in their demeanor and interactions with others; however, their underlying anger is often expressed through sarcasm and passive aggressiveness. These passive expressions and periodic outbursts of rage can be hints about pervasive underlying anger. Picking also can be a passive-aggressive manifestation of a patient's anger. A classic example is the picker whose picking upsets or even infuriates the nonpicking partner or parent. The passive indifference displayed by an adolescent with acne excoriee who comes to a clinic accompanied by a distraught parent is a common presentation. This form of emotional manipulation is typical, and the dynamics of the picking and its role in the relationship are rarely evident to the picker. The clinician must realize that angry pickers may find the idea of relinquishing the picking act to be frightening due to fear of their underlying impulses. The picking behavior often affords patients a sense of control over both themselves and others. The excoriations of the angry picker often become functionally autonomous (a self-maintaining function independent of the initial eliciting factors) and may evolve into an obsessive-compulsive pattern. The goal of treatment is to help patients reduce and more effectively dissipate their anger while more effectively manipulating their environment in a less self-injurious fashion. Concrete behavioral alternatives, aggressive exercise, competitive sports such as kickboxing or karate, relaxation training, and insight-oriented psychotherapy can be helpful in decreasing the picking of these patients. Concomitant use of selective serotonin reuptake inhibitors (SSRIs) or anxiolytic medications can be helpful in treating underlying depression, agitation, and associated obsessive-compulsive components.

Table 2.

Selected Anxiolytic, Antidepressant, and Antipsychotic Medications for Management of Picking*

Acute Anxiety

Benzodiazepines

- Alprazolam: 0.25–1 mg every 6–8 h PRN
- Clonazepam: 0.25–0.5 mg every 6–8 h PRN
- Lorazepam: 0.5 mg every 8 h PRN

Long-standing Anxiety

Add concomitant nonbenzodiazepine

- Buspirone 5–15 mg TID

Depression

SSRIs—all can be activating or sedating; most can decrease libido

- Fluoxetine: for depression, start at 10–20 mg QD, titrate to 40–60; for OCD, start at 60–80 mg
- Sertraline: for depression, start at 25–50 mg QD, titrate to 100 mg (single or divided doses); for OCD, dose up to 200 mg QD
- Paroxetine: for depression, start at 10–20 mg QD; for OCD, start at 20–40 mg QD
- Fluvoxamine: for depression, start at 50 mg QD, titrate to 200 mg; for OCD, titrate to 200–300 mg QD
- Escitalopram: for depression, start at 10 mg QD, maximum 20 mg QD
- Bupropion: for depression and anxiety, start at 75 mg QD, titrate to 300 mg if necessary

Tricyclic antidepressants: all can have sedating and anticholinergic effects

- Doxepin: start at 10–25 mg HS, titrate to 75–100 mg QD (single or divided doses)
- Trimipramine: start at 25 mg HS, titrate to 75 mg HS

Psychosis or Severely Destructive Excoriations

Olanzapine: start at 1.25–2.5 mg QD, titrate to 5 mg QD TID

Pimozide: start at 1 mg HS, titrate to 6 mg HS

Haloperidol: start at 1 mg HS, titrate to 2 mg HS

Risperidone: start at 0.5 mg QD, titrate to 2 mg QD

*PRN indicates as occasion requires; TID, 3 times daily; SSRIs, selective serotonin reuptake inhibitors; BID, 2 times daily; QD, every day; OCD, obsessive-compulsive disorder; HS, hour of sleep (bedtime).

The Anxious/Depressed Picker

Picking is common among anxious and depressed patients. A review by Phillips and Taub[3] suggested that 88% of patients with major depression and 58% of patients with anxiety disorders pick their skin. The clinical disfigurement that follows can lead to exacerbation of the depression and anxiety state, with subsequent tendency toward more self-excoriation. Management of the anxious/depressed picker should be initiated by offering the patient insight and hope. Anxiety and depressive disorders often have an insidious onset, and symptoms are frequently not recognized by the patient. Patients often attribute symptoms to age, declining health, etc. The astute clinician can elucidate associated anxiety and depression by asking pertinent questions such as, "Are your feelings of tension, fatigue, or sadness interfering with your ability to be happy or do the

things you want or need to do?" Ask patients if they experience pleasurable sensations from activities such as eating, exercising, and sex. Ask how they feel before and after they pick their skin. Patients often report increased levels of anxiety or depression that are transiently decreased by their picking.

Tell patients there are techniques and medications that can make them feel less stressed and happier. If there is no active suicidal or homicidal ideation of intent, offer patients referrals for stress management, biofeedback, cognitive behavioral or insight-oriented psychotherapy, or hypnosis. Cognitive behavioral psychotherapy helps individuals identify and change self-defeating thoughts and perceptions that lead to negative emotional reactions and maladaptive behaviors. Helping patients decrease their tendency to view life events as awful or catastrophic can decrease their anxiety and depression and lessen the urge to pick. Insight-oriented psychotherapy helps patients identify emotions, thoughts, and behavior patterns and make meaningful emotional and behavioral changes. The result is often decreased subjective stress, improved insight into motivation for picking, and decreased urge to pick. Concomitant use of an appropriate psychotropic agent as an adjunct to traditional dermatologic therapy can be useful. Table 3 lists the common signs and symptoms of anxiety and depression.

Table 3.

Common Signs and Symptoms of Depression and Anxiety

Anxiety
Gastrointestinal upset
Hyperhidrosis
Jitteriness (tremulousness)
Panic attacks
Poor attention span
Restlessness
Tachycardia (palpitations)
Depression
Anhedonia (inability to experience pleasure)
Blunted (constricted affect)
Decreased libido
Hyperphagia/hypophagia
Hypersomnia/hyposomnia
Limited spontaneous verbalizations
Poor eye contact

The Body Dysmorphic Picker

The body dysmorphic picker shares many similarities with the narcissistic picker. Both can present with extreme preoccupation with minimal cosmetic imperfection. However, body dysmorphic pickers often have greater distortions in their perception of their skin "defect" and carry a much higher rate of morbidity and mortality. These are individuals preoccupied with a minimal or imagined defect in appearance. Their exaggerated and distorted perceptions cause significant emotional distress and/or impairment in social, occupational, or other important areas of functioning. Patients commonly present with exaggerated preoccupation with and excessive manipulation of acneform lesions, telangiectasias, nevi, etc. Their preoccupation and skin manipulation can have devastating emotional and functional consequences with substantial associated morbidity and mortality. Phillips et al[3] and Koblenzer[9] stated that BDD is a relatively common disorder that often involves preoccupation with the skin.

Overlap between BDD and OCD may exist.[9-12] This claim is somewhat substantiated by the fact that both disorders respond favorably to treatment with SSRIs.[13] Also, both BDD and OCD often have repetitive behaviors that provide individuals with immediate reduction in tension; however, the behaviors and their sequelae often lead to even more severe rebound anxiety, depression, and perseveration. Picking often occurs for extended periods (for hours a day) in front of a mirror. People with BDD have significant associated morbidity with a high frequency of social or occupational impairment. Many become housebound, and psychiatric hospitalizations and suicide attempts are not uncommon.[4]

Treatment of individuals with BDD is difficult. Because there is frequently substantial impairment in functioning, as well as suicide potential, aggressive modalities are warranted. An SSRI and adjunctive psychotherapy are essential and should be strongly recommended by the clinician. Use of a low-dose antipsychotic medication can be helpful. Vigilance should be maintained for signs of accelerating

depression or suicidal ideation and appropriate referral to a psychiatric professional should be made.

The Borderline Picker

The borderline picker is characterized by enormous affective instability, chronic feelings of emptiness, boredom, and unhappiness. Poor judgment and limited impulse control further define these individuals, and their picking is often only one of many self-injurious activities that highlight their present and past behaviors. Clues to the borderline picker may include scars from suicide attempts, cigarette burns, or self-inflicted wounds. These self-destructive acts are performed in response to anger or anxiety or as an attempt to "feel something." The borderline picker often has a history of alcohol or drug abuse and interpersonal relationships that were marred by excessive lability (ie, vicious verbal and physical fighting). The work history of these individuals is often unstable, and relationships with previous physicians are commonly described as unsatisfactory. Initial therapeutic encounters with these patients may be unusually pleasant for the physician (excessive praise and overly ingratiating statements offered by the patient). However, the physician inevitably becomes a target of the patient's anger and disappointment when clinical success is not immediate and complete. Borderline pickers often violate the boundaries of the doctor-patient relationship and have exaggerated expectations of physician availability and duration of visits.

Treatment of the borderline picker is often difficult and unsuccessful because of their predisposition to ongoing self-injurious behavior, poor judgment, and poor impulse control. The underlying chronic depression experienced by these patients can be somewhat ameliorated by the use of antidepressant medications, and the anxiety and chronic agitation of borderline pickers can be somewhat responsive to anxiolytic medications. Benzodiazepine anxiolytics can be problematic because there is frequently a high potential for addiction or abuse. Narcissistic preoccupation is frequently common and can be useful as a starting point to engage the patient in treatment. Statements such as "I don't want to see you become scarred" or "I am fearful that your picking will lead to permanent scars" can be helpful. Initially, offer patients quick-fix therapies such as topical steroids, mentholated compounds, topical antihistamines, and moisturizers. Concrete alternative behaviors such as deep breathing exercises, gentle slapping of lesions, application of cold packs, and palm or finger pressure on lesions can be helpful distraction methods. More formal intervention such as progressive muscle relaxation, meditation, and biofeedback also can be helpful. Borderline pickers can become moderately bizarre, even delusional, under stressful situations. During acutely agitated states, anxiolytic and antipsychotic medications may be necessary. These patients will continually demand novel therapies and will invariably find your therapeutic offerings ineffective. Long-term psychotherapy is advocated when possible for effective treatment of this severe characterologic disorder.

The Delusional Picker

The picking behavior of the delusional picker is, by definition, motivated by a rigidly held belief that is not based on reality. The delusional belief can be limited to skin infestation or skin defect (monosymptomatic hypochondriacal delusion). In contrast, the delusional belief can be part of a more pervasive delusional disorder with many other misperceptions of reality. Delusions of parasitosis (monosymptomatic hypochondriacal psychosis) is the classic example of a circumscribed delusional system. These patients rigidly maintain a belief of infestation with an insect or parasite, and their picking is an attempt to eradicate or modify the infestation. They are otherwise without active delusional ideation. These delusional pickers often respond favorably to treatment with pimozide,[11] and recent data suggest possible favorable responses to treatment with olanzapine and risperidone.[14] Patients with more generalized delusional systems are in need of standard antipsychotic medication and often require periodic psychiatric hospitalization. It is important that the clinician avoid challenging the patient's delusional beliefs. Disputing the patient's ideas and attempting to force reality-based perceptions on the patient will jeopardize the therapeutic alliance. In fact, it may even be dangerous if the physician is perceived as a threat within the patient's delusional system. Accepting the patient's delusional beliefs as real and important will yield the greatest chance of a safe and effective alliance. If the delusional belief is circumscribed, as in the patient with delusions of parasitosis, treatment with pimozide or olanzapine may be helpful. More generalized delusional disorders usually require standard psychiatric referral.

The Guilty Picker

Guilt is a subjective experience of emotional discomfort that is encountered by all individuals with a conscience. A basic fear of retribution occurs when individuals perceive their thoughts or deeds as wrong, impure, or evil at either a conscious or unconscious level. Guilt can be a facilitative motivator for

prosocial behavior or, in contrast, it can be a pervasive destructive force that leads to intrapsychic misery and self-punitive behavior. The compulsive hand washing described in Shakespeare's *Macbeth* may be conceptualized within our framework as the guilty washer. The fearful, guilt-ridden individual may pick incessantly as a self-punitive gesture or as an attempt to rid oneself of impurity or infection. The guilt and accompanying fear may be reality-based, as in the individual who engages in an extramarital affair and is fearful that he or she has contracted a sexually transmitted disease. More often, the guilt is in response to minimal behavioral indiscretions or unacceptable thoughts or fantasies. The guilt is often buttressed by cultural and religious beliefs regarding retribution, which can cause individuals to ruminate, perseverate, and repeatedly excoriate. Excoriated lichen simplex chronicus of the scrotum or pruritus ani may be symptoms of persistent guilt and fear of retribution for unacceptable thoughts or acts in patients presenting with these conditions.

Supportive clinicians who appropriately educate their patients can often assuage some of the guilt of these individuals and thus allow them to minimize ongoing self-punitive behavior. Appropriate diagnostic tests for conditions such as chlamydia, syphilis, gonorrhea, and human immunodeficiency virus should be performed if patient history or clinical suspicion warrant. Gentle reassurance and humor can often allay anxiety for these patients and provide them with perspective. Patients who pick incessantly because of fantasies of an extramarital affair can often be reassured that this is a common fantasy for which there is no punishment. Offering concrete alternative behaviors can be helpful. If substantial guilt is still present, short-term cognitive behavioral psychotherapy, insight-oriented psychotherapy, SSRIs, and anxiolytic medications all can be helpful in treating associated depression, anxiety, and obsessive-compulsive symptoms.

The Habit Picker

All individuals develop mechanisms and techniques to dissipate anxiety. In contrast to the obsessive-compulsive picker, the habit picker has no associated obsessions or compulsive ritualistic behaviors. The habit picker probably stumbles upon a simple behavior to reduce underlying anxiety. For some, hair twirling may be effective, while for others, rocking, rubbing, eating, smoking, or masturbating may be their chosen methods. The nail picker who presents with median nail dystrophy or the patient with scalp lesions who presents with small excoriated nodules on the posterior scalp are classic examples of the habit picker. The picking of the habit picker is usually milder and more anatomically localized in comparison with those patients with more severe psychopathology or classic neurotic excoriations. The overall functional status of these patients is usually very good. Sometimes they simply need insight and awareness and can respond extremely well to behavior modification incorporated with alternative behaviors as well as hypnosis. Simple occlusion, topical and intralesional corticosteroids, topical antihistamines (doxepin), mentholated compounds, and topical lidocaine preparations all can be helpful. Excoriations of the habit picker can evolve into an obsessive-compulsive pattern; therefore, in chronic resistant cases, the use of an SSRI may be helpful.

The Narcissistic Picker

The narcissistic picker self-excoriates because of an inability to accept imperfection. These individuals are by definition self-preoccupied and can spend long periods of time seated in front of a mirror studying their real, minimal, or imagined imperfections. They pick as an attempt to rid themselves of an intolerable mar on an otherwise perfect picture. Narcissistic patients are often impossible to please because they crave and demand perfection and constant attention. Their insatiable appetite for attention, recognition, and perfection leads them to numerous cosmetic, medical, and surgical specialists in search of the unattainable. They are frequently bitter and angry because of inadequate attention from loved ones and imperfect therapeutic outcomes rendered by healthcare professionals. Primary or secondary depression and OCD are not uncommon.

Treatment of the narcissistic picker is a long and often unsuccessful endeavor. It is common for the physician to feel drained or exploited after repeated contact with a narcissistic patient. Clinicians should be aware of the intense subjective discomfort experienced by these patients and should avoid minimizing the importance of the patient's perceived imperfections. Emotional support and tactful attempts to provide reality-based objective assessment of the imperfections are a starting point of therapy. Avoidance of overly aggressive medical and surgical therapies is strongly advised because they will inevitably fall short of the patient's expectations. It may be helpful to treat concomitant depression, anxiety, and possible obsessive-compulsive patterns by using SSRIs and anxiolytic medications. Cosmetic camouflage may be helpful in allowing patients to not focus on the imperfection as their treatment progresses. Concomitant psychotherapy is often desirable if the patient will accept the recommendation.

Table 4.

Organic Etiologies Associated With Skin Excoriations

Dermatologic Conditions
Acne/folliculitis
Dermatitis herpetiformis
Eczema
Infestation
Lichen planus
Psoriasis
Urticaria
Systemic Conditions
Amyloid tumor
Carcinoid
Diabetes
Drug reactions
Hepatic disease
Hodgkin's disease
Human immunodeficiency virus
Lupus
Multiple sclerosis
Polycythemia vera
Renal disease
Sjögren syndrome
Neuropsychiatric Conditions
Alcohol, cocaine, other substance intoxication
Alzheimer disease
Parkinson disease
Pervasive developmental disorder
Prader-Willi syndrome
Stereotypic movement disorders
Tourette syndrome

The Obsessive-Compulsive Picker

OCD is characterized by intrusive, obsessive thoughts accompanied by or leading to compulsive, ritualistic acts. The thoughts and behaviors often lead to psychosocial impairment and/or dermatologic problems. Common clinical presentations include acne excoriee, excoriated lichen simplex chronicus, and neurotic excoriations. Affected individuals report increased tension and anxiety preceding performance of the ritualistic act, which is temporarily reduced by performance of the act. When the act is detrimental or disfiguring, it is common for individuals to experience increased agitation and anguish. This emotional discomfort can lead to additional picking and perpetuation of the cycle. The picking of patients with OCD may be a manifestation of a single compulsive act or may be only one of several compulsions. There may be other ritualistic acts, including checking, cleaning, and rubbing. The need for treatment is determined by the degree to which the obsessions or compulsions disfigure or scar the skin or interfere with the psychosocial functioning of patients.

Successful treatment is directed at decreasing the compulsive urge and empowering patients to better control their picking behavior. The practitioner should recognize that asking patients to relinquish the compulsive act can arouse tremendous subjective anxiety because the picking has evolved as a maladaptive but important method to decrease anxiety and maintain control. Bearing this in mind, treatment of the obsessive-compulsive picker must be initiated with gentle support and a clear message to patients that they may maintain control. First-line treatment should be an SSRI. Clinicians should introduce the medication with the suggestion that it will help patients increase control over their picking behavior. Explain that the medicine will decrease the intensity of the urge to pick and the associated emotional subjective discomfort. Once the urge to pick has been lessened, patients are often better able to embrace and develop alternative behaviors. Offer concrete alternative behaviors such as deep breathing, relaxation training (available in audiotape form in local bookstores), imagery techniques (such as relaxing scenes, healing healthy skin, sunlight, soothing sensations), squeezing of fists, application of pressure, cold compresses, and application of medications. Concomitant cognitive behavioral or supportive psychotherapy is often helpful. Behavior modification techniques often are used to enable patients to break conditioned stimulus-response emotional and behavioral associations (eg, picking while in traffic, watching television, in front of the bathroom mirror). Dermatologic therapies including

topical and intralesional corticosteroids, occlusion, topical or oral antibiotics, mentholated compounds, tar preparations, topical lidocaine creams, and topical antihistamine therapies may be helpful as well. Newer topical immunosuppressant agents such as pimecrolimus and tacrolimus may be useful if recalcitrant pruritus is present. Nighttime use of a tricyclic antidepressant may be helpful if there is associated sleep impairment or nocturnal itching.

The Organic Picker

Many organic states lead patients to excoriate. The excoriation of the organic picker may be in response to itch or other cutaneous dysesthesia or to part of a more complex motoric manifestation of another syndrome. Table 4 lists a number of common dermatologic, systemic, and neuropsychiatric conditions that can lead patients to excoriate their skin.

If the underlying organic state is treatable, complete eradication of associated cutaneous sensations (if present) and self-excoriation may be possible. Identification of reproducible patterns of excoriation can help in both diagnosis and treatment.

Conclusion

Substantial overlap exists between the 10 groups of pickers. Clearly, many patients do not fit neatly into one of the described categories, and definitive placement within a given group may be difficult. Despite these shortcomings, we believe that it is helpful to conceptually categorize the patient who stands before you with active excoriations into one of these groups so that rational treatment planning may take place. Akin to the patient presenting with fever of unknown origin, algorithms and categorization can be helpful in approaching these patients in an organized fashion. The degree to which any practicing clinician wishes to venture into psychodermatology certainly varies. We maintain that all clinicians should practice a significant amount of psychodermatology by conveying empathy and hope for patients. Further, the burden of comprehensive medical and emotional care is most often placed on the nonpsychiatrist. It is hoped that this conceptual framework will provide useful treatment recommendations that will lead to better therapeutic outcomes.

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