The Relation of Psychogenic Excoriation With Psychiatric Disorders: A Comparative Study

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Psychogenic excoriation (PE), characterized by excessive scratching or picking of the skin, is not yet recognized as a symptom of a distinct DSM-IV disorder. It is a chronic disorder with a high rate of psychiatric comorbidity. The purpose of this study was to compare patients diagnosed with PE and patients with another dermatological disease in terms of comorbid psychiatric disorders. Thirty-one consecutive subjects were recruited from an outpatient dermatology clinic. The control group was composed of 31 patients with chronic urticaria. All subjects were interviewed using the Structured Clinical Interview for DSM-III-R (SCID-I), Beck Depression Inventory (BDI), Hamilton Anxiety Rating Scale (HARS), and Yale-Brown Obsession and Compulsion Scale (Y-BOCS) and also completed a semistructured questionnaire. Current major depressive syndrome was the most common psychiatric disorder in the PE group. There was a statistically significant difference between the two groups in terms of current major depressive syndrome (PE group 58.1%, control group 6.5%, $P < .01$). In the PE group, 45.2% of subjects were diagnosed with obsessive compulsive disorder (OCD), while the rate of OCD was only 3.7% in the control group ($P < .01$). The PE group scored significantly higher on the BDI, HARS, and Y-BOCS. The results of this study point to the close relationship of PE to depression and OCD.

THE RELATION BETWEEN psychological factors and certain dermatological diseases has been mentioned by several authors.[1-4] Psychogenic excoriation (PE), which has a significant place among the dermatoses related to psychological factors, is characterized by an intense urge for scratching, picking, gouging, or squeezing of otherwise healthy skin.[5-8] It is estimated to occur in about 2% of dermatology clinic patients, predominantly women.[9] The description of lesions related to PE dates back to approximately 100 years ago.[10] It has been reported to be associated with a primary psychiatric disorder.[5,6,11,12]

There are also other disorders among dermatological diseases that are influenced by psychological factors. However, some of these primary dermatological diseases (such as psoriasis, atopic dermatitis, alopecia areata, urticaria) are caused by psychophysiological mechanisms rather than being dermatological manifestations of a psychiatric disorder as PE is.[6,13]

PE is not yet recognized as a distinct psychiatric disorder classified in the DSM-IV.[8] The number of controlled studies on this subject conducted in the field of psychiatry is surprisingly low.[6,10]

Depression, obsessive compulsive disorder (OCD), anxiety, and hypochondriasis are the leading axis I psychiatric disorders considered to be associated with PE.[10,14] Personality disorders are also common, with obsessive-compulsive personality disorder the most common, followed by borderline personality disorder.[15] However, the referral of patients with PE to a psychiatry clinic and thus their receiving adequate treatment is usually delayed despite their important psychological problems. Therefore the clarification and specification of the psychopathology that is present can be useful for both dermatologists and psychiatrists in their approach to patients with PE. In the classifications of psychodermatoses, PE is classified under the title of conditions strictly psychological in origin[16] or dermatological syndromes based on psychiatric problems.[17] On the contrary, psychological factors appear not to have a principal but a helping role in the development of chronic urticaria.[16] The objective of this study was to evaluate patients diagnosed as PE in a dermatology clinic and another group of patients with chronic urticaria in terms of comorbid axis I psychiatric disorders and to compare their levels of depression, anxiety, and obsessive-compulsive symptoms.

METHOD

Thirty-one patients diagnosed with PE in a dermatology outpatient clinic were recruited consecutively for the study. The subjects were older than 18 years of age, were at least primary school graduates, and provided written informed consent to participate in the study. Having a serious physical disease, a psychotic disorder, or any internal disease that could cause itching were defined as exclusion criteria. Internal diseases such

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0010-440X/03/4403-0023$30.00/0

doi:10.1053/comp.2003.50021

Table 1. Age, Age of Onset, and Duration of Disease in the Psychogenic Excoriation and Control Group

Variable	PE Group (n = 31)	Control Group (n = 31)	*t*	χ^2
Age, yr (mean ± SD)	34.1 ± 14.2	35.4 ± 9.4	0.44	
Age of onset, yr (mean ± SD)	30.2 ± 12.3	30.6 ± 10.9	0.16	
Duration of disease, mo (mean ± SD)	45.2 ± 67.6	60.3 ± 100.5	0.69	
Gender (female)	24 (77.4%)	23 (74.2%)		0.08
Marital status (married)	19 (61.3%)	22 (71.1%)		3.21

as malignant lymphoma, leukemia, diabetes mellitus, thyrotoxicosis, polycytemia vera, renal failure, and liver diseases can cause itching and excoriation.[7] Physical examination and laboratory investigation were used to determine and exclude such diseases that could result in itching and, thus, excoriation. Laboratory investigations undertaken were complete blood count, urinary examination, erythrocyte sedimentation rate, blood glucose level, AST, ALT, apolipoproteins, billirubin, urea, calcium, iron, iron-bonding capacity, serum and urine electrophoresis, parasite in feces, cellophane bandage test, and thyroid function tests. The control group, which complied with the inclusion and exclusion criteria, was composed of 31 patients with chronic urticaria.

After dermatologic and laboratory examination, a structured psychiatric interview and the following scales were applied to all patients in the study and control groups. The Structured Clinical Interview for DSM-III-R (SCID-I) was used in order to make psychiatric diagnosis.[18] All subjects were evaluated in terms of axis I disorders using this assessment instrument, which is more objective than an unstructured psychiatric interview. Although the DSM-IV is currently available in Turkey, the Turkish version of the SCID- I was not available during the period of study. Therefore, SCID-I for DSM-III-R was used.[19] A semistructured questionnaire including sociodemographic characteristics, psychiatric history, and clinical features was applied. The Beck Depression Inventory (BDI) was used to measure current self-reported symptoms of depression. Each of 21 items on the BDI measures the presence and severity of a symptom of depression by requiring a self-rating from 0 to 3. The score is determined by summing the ratings for the individual items.[20] The Hamilton Anxiety Rating Scale (HARS), a clinician-rating scale used to measure the level of anxiety, symptom range, and change of severity, contains 14 questions.[21] The rating of each item is between 0 and 4 and the score is determined by summing the ratings for the individual items. The Yale-Brown Obsession and Compulsion Rating Scale (Y-BOCS) was used to determine the type and measure the severity of obsessive compulsive symptoms.[22,23] It is composed of two sections, namely, the Y-BOC symptom checklist and the Y-BOC rating scale. Questions 1 to 5 in the rating scale evaluate the severity of obsessions and questions 6 to 10 evaluate that of compulsions. Questions 11 to 18, which were added to the scale for experimental purposes, were not evaluated. The validity and reliability of all of these scales in Turkish has been studied.[24-26]

Results were analyzed using the Statistical Package for the Social Sciences (SPSS version 5.01). As the distribution was normal, categorical data were compared using the chi-square test and continuous data using Student's *t* test.

RESULTS

The age of the patients at the time of presentation ranged from 18 to 63 years (mean ± SD, 34 ± 14 years) in the PE group and from 29 to 52 years (35 ± 9 years) in the control group. There were no statistically significant differences between the groups in terms of age, sex, age of onset, duration of illness, and marital status (Table 1).

Lesions due to the excoriations were mostly placed on the upper and lower extremities. The distribution of lesions is summarized in Table 2.

Current major depressive syndrome was the leading psychiatric disorder in the PE group according to the diagnostic interview using the SCID- I. Eighteen of the patients in this group (58.1%) and two patients (6.5%) in the control group had current major depressive disorder and this difference was statistically significant ($\chi^2 = 18.89$, $P < .01$). OCD was diagnosed in 14 of the patients with PE (45.2%) and in three of those in control group (9.7%). This difference was also statistically significant ($\chi^2 = 9.80$, $P < .01$). No statistically significant difference was observed between the two groups with respect to other psychiatric comorbidities (Table 3).

While the average scores on BDI indicated moderate levels of depression in PE group, the average value in control group was below the depression limit. The differences between the average scores of patients in the PE and control groups on the BDI

Table 2. Location of Skin Lesions in the Psychogenic Excoriation Group

	n	%
Arms	24	77.4
Legs	18	58.1
Face	13	41.9
Back	9	29.0
Neck	8	25.8
Abdomen	7	22.6