

It is illegal to post this copyrighted PDF on any website.

# A Brief Review of Dermatitis Artefacta and Management Strategies for Physicians

Swathi Shivakumar, MD<sup>a</sup>; Mohammad Jafferany, MD<sup>b</sup>;  
Sushruth Vinaya Kumar, MD<sup>c</sup>; and Sneha Sood, MBBS, DDVL<sup>c,\*</sup>

## ABSTRACT

Dermatitis artefacta, an enigmatic entity with often bizarre and widely variable presentations, can be a challenge to diagnose and treat. Although it is classified as a primary psychiatric disorder, patients are often oblivious that the lesions are self-inflicted and thus consult a physician. Therefore, it becomes imperative to be aware of this condition and to build a good rapport with patients so as to counsel them on the need to seek care for their underlying psychiatric stressors. This narrative review focuses on reaching a proper diagnosis, addressing associated psychological morbidity, and formulating treatment approaches.

*Prim Care Companion CNS Disord* 2021;23(4):20nr02858

**To cite:** Shivakumar S, Jafferany M, Kumar SV, et al. A brief review of dermatitis artefacta and management strategies for physicians. *Prim Care Companion CNS Disord*. 2021;23(4):20nr02858.

**To share:** <https://doi.org/10.4088/PCC.20nr02858>

© Copyright 2021 Physicians Postgraduate Press, Inc.

<sup>a</sup>Deepak Hospital, Bangalore, India

<sup>b</sup>Central Michigan University, Saginaw, Michigan

<sup>c</sup>Beautiful Mind Healthcare, Bengaluru, Karnataka, India

\*Corresponding author: Sneha Sood, MBBS, DDVL, Beautiful Mind Healthcare, 161, 9th Cross, Indira Nagar 1st State, Bangalore-38, Bengaluru, Karnataka, India (snehasood88@gmail.com).

**D**ermatitis artefacta refers to a condition in which the skin lesions are a result of deliberate and conscious self-inflicted injury and not due to any underlying pathology. The self-inflicted injury is done to satisfy an unconscious emotional or psychological need.<sup>1</sup> Dermatitis artefacta is considered a primary psychiatric condition in which the lesions are factitious, and patients often have an underlying personality disorder.<sup>2,3</sup> The clinical appearance of these lesions varies greatly due to the various agents used to inflict injury to the skin, causing a diagnostic dilemma for an unsuspecting physician.<sup>4</sup> However, the characteristic finding in these patients is the presence of these lesions only over the accessible parts of the body. Another peculiar clue is the patient's marked indifference to his/her skin lesions despite their severity.<sup>5</sup> Even after a diagnosis is made, the greater challenge lies in management, as these patients are often in denial about their condition and the need to seek psychiatric care.<sup>6</sup> The objective of this review is to increase awareness of dermatitis artefacta and to encourage physicians to have a high index of suspicion and to work in liaison with multidisciplinary clinics to provide optimal care for these patients.

## ETIOPATHOGENESIS/PREDISPOSING FACTORS

The etiology of dermatitis artefacta is multifactorial. As with most psychodermatologic conditions, the origin of dermatitis artefacta can be traced back to the formative years, with patients having a history of strained relationships and emotional distress from events such as loss of a parent, parental divorce, a broken home, or sexual, emotional, or physical abuse. As a result, they fail to develop a stable body image and have an immature personality.<sup>7,8</sup> Dermatitis artefacta has been reported in association with borderline personality disorder, posttraumatic stress disorder (PTSD), and depression.<sup>9</sup> There are a few isolated case reports<sup>10</sup> of patients with dermatitis artefacta having alcohol dependency and drug abuse, although the significance of this association is undetermined. It was found that patients with PTSD self-induce the skin lesions during periods of dissociation and thus have no recollection of the event.<sup>6</sup> Patients with dermatitis artefacta tend to have a deep sense of loneliness and use self-infliction to fill a void of which they themselves are unaware.<sup>11,12</sup> Hence, dermatitis artefacta can be thought of as a somatization of an underlying psychiatric disorder, although not a true somatic disorder as such. Stress is known to trigger episodes of dermatitis artefacta, although the exact mechanism is unknown.<sup>13</sup>

## EPIDEMIOLOGY

Dermatitis artefacta is grossly underdiagnosed; thus, it is difficult to correctly ascertain its prevalence. One study<sup>14</sup> reported that

### Clinical Points

- A characteristic finding of dermatitis artefacta is patients' lack of concern about their lesions even if very severe, which is in stark contrast to reactions of their families.
- On examination, an important finding is that dermatitis artefacta lesions are located on easily accessible parts of the body like the face, extremities, and anterior aspect of the trunk.
- An impassive but cooperative patient presenting with bizarre-shaped lesions over the accessible regions on the body should alert the dermatologist to consider dermatitis artefacta.
- Another clue in the diagnosis of dermatitis artefacta is the improvement of lesions following occlusive dressings, as this limits the patient's access to that site.

dermatitis artefacta represents approximately one-third of psychiatric patients that visit the dermatologist clinic every year. In another study from Iran,<sup>15</sup> the relative incidence of dermatitis artefacta among psychodermatology patients was found to be 6.7%. Although the condition may be seen at any age, it is more common in early adulthood, just after adolescence.<sup>13</sup> It is reported more often in females, with a female to male ratio ranging from 2.8:1 to 20:1 in different studies.<sup>13,16</sup> It is also found to be more prevalent among women of lower socioeconomic strata.<sup>17</sup>

### CLINICAL FEATURES

The clinical presentation of dermatitis artefacta is highly variable depending on the mode of injury used like fingernails, sharp or blunt object, or chemicals.<sup>18</sup> It can range from mild excoriations, abrasions, and blisters to deep ulcers and burns.<sup>6</sup> Previous studies<sup>19</sup> have shown that excoriations are the most common type of lesions in dermatitis artefacta, followed by ulcers. The lesions may be linear or angular, unilateral or bilateral, or single or multiple. The history provided by the patient is usually vague, with the lesions appearing suddenly and with no apparent cause.<sup>5</sup> Patients deny any role in its causation, as they often dissociate while they self-inflict. A characteristic finding is patients' lack of concern about their lesions even if very severe, which is in stark contrast to reactions of their family. On examination, another important finding is that these lesions are located on easily accessible parts of the body like the face, extremities, and anterior aspect of the trunk. They may appear bizarre in shape, and different types of lesions may be seen at different sites.<sup>20</sup> Although some patients may have multiple lesions at different stages of healing, most present with apparently nonhealing lesions. The lesions appear clearly demarcated with the intervening skin appearing normal.<sup>21</sup> The patient may also have a vast history of previous investigations for similar complaints.<sup>7,16</sup>

Dermatitis artefacta is frequently found in association with other psychiatric disorders, especially borderline personality disorder.<sup>22</sup> Borderline personality disorder is

characterized by emotional instability, lack of impulse control, unstable relationships, and severe psychosocial impairment. These patients have an alarmingly high rate of self-harm and suicide as a consequence of their impulsive nature.<sup>23</sup>

Dermatitis artefacta may also result in response to stressful conditions, and it is frequently found in association with PTSD.<sup>24</sup> In PTSD, patients self-inflict during periods of dissociation and thus are unaware of how it occurred, which may lead to a misdiagnosis of malingering. The cutaneous symptoms tend to wax and wane, and on careful probing, they are found to typically aggravate during periods of stress.<sup>25</sup> Figure 1A–D provides examples of these self-inflicted skin injuries.

### DIFFERENTIAL DIAGNOSIS

Dermatitis artefacta has no specific clinical appearance, and the lesions may vary as vastly as the patient's imagination. It may resemble almost any dermatologic condition, such as vasculitis, pyogenic granuloma, or cutaneous T-cell lymphoma.<sup>26,27</sup> Sometimes, a histopathologic analysis of a biopsy specimen is utilized to rule out other dermatologic conditions. But, once a diagnosis of self-induced dermatosis is made, the main challenge is to rule out malingering, deliberate self-harm, Munchausen's syndrome, delusions, and neurotic excoriations.

*Deliberate self-harm* is a broad term that includes habitual wrist cutters and those with suicidal ideation. Many of these patients have associated depression, borderline personality disorder, and other psychiatric comorbidities. On questioning, they accept that their lesions are self-induced.

Patients with neurotic excoriations have an irresistible urge to scratch their skin, which aids to relieve their stress. They too accept that their lesions are self-induced.<sup>28</sup>

Patients with delusional parasitosis believe that they are infested with bugs and may attempt to pick or dig out their skin in an attempt to remove the insect. They often bring the plucked skin in a box to show the physician—the characteristic “matchbox sign.”<sup>29</sup>

Malingers, in contrast, deny any role in the causation of lesions and may often be mistaken as having dermatitis artefacta. However, on careful history, it is obvious that these patients produce these lesions to obtain financial gain or to avoid responsibility and not due to a psychiatric illness.

Patients with Munchausen's syndrome do not self-inflict to obtain any secondary gain, but rather to attract attention. They have a very vivid description of their symptoms and a tendency for doctor shopping. Their symptoms need not be limited to the skin.<sup>30</sup>

### WORKUP

The diagnosis of dermatitis artefacta requires a high index of suspicion. Other common dermatoses must be ruled out with careful history, examination, and investigations if required. Skin biopsy is often inconclusive and serves to only rule out a suspected dermatologic condition. An impassive



It is illegal to post this copyrighted PDF on any website

Figure 1. Self-Inflicted Skin Injuries<sup>a</sup>



<sup>a</sup>Permission was received from all patients to publish these photos.

You are prohibited from making this PDF publicly available.

yet cooperative patient presenting with bizarre-shaped lesions over the accessible regions on the body should alert the dermatologist to consider dermatitis artefacta. Another clue is the improvement of lesions following occlusive dressings, as this limits the patient's access to that site.<sup>31</sup> Further probing into immediate and childhood history may indicate an underlying stressful event that could have triggered the self-infliction and reveal a personality disorder in some. However, a cautious approach must be taken while disclosing the nature of illness to the patient. Direct confrontation should be avoided at all costs.<sup>32</sup> Suggesting a psychiatric opinion prematurely, before building a rapport, may cause the patient to lose trust in the treating physician and be lost to follow-up.<sup>10,33</sup>

## MANAGEMENT GUIDELINES

The management of dermatitis artefacta is multifaceted and quite complex and chronic, as these patients often have underlying personality disorders that need to be addressed. As already discussed, these patients present primarily to a general physician and often lack insight on the self-induced nature of the lesions. They should be handled with utmost sensitivity, avoiding any confrontation about the condition. Wound care with occlusive dressings, topical antibiotics if required, and regular follow-up is sufficient for physical healing of the lesions in most cases.<sup>34</sup> Once a good doctor-patient relationship is established, these patients should be gently encouraged to seek psychiatric consultation.

## COUNSELING

Good empathetic psychiatric counseling goes a long way in the management of dermatitis artefacta, especially in those with personality disorders. Once the diagnosis of borderline personality disorder is established, much of the early treatment is focused on the value of intensive exploratory psychotherapies to identify the basic character structure of patients with dermatitis artefacta.

Literature<sup>32-34</sup> has increasingly suggested that improvement may be related to developing a stable, trusting relationship with the therapist. A nonconfrontational approach and neutral attitude is the key to treatment. Special focus should be paid to obtaining a history of childhood abuse and trauma. The patient is informed that although a medical problem exists, it is related to psychological factors.

## PSYCHOTHERAPY

Psychotherapy is a type of treatment process wherein the thoughts, emotions, and behavior of a person are modified so as to improve their life functioning. The different categories of psychotherapy used in dermatitis artefacta are psychodynamic psychotherapy (PDT), cognitive-behavioral therapy (CBT), and family therapy. Psychotherapy is the first-line treatment for patients with dermatitis artefacta and underlying personality disorders.

Among the different treatment types, PDT has been found to be most useful, as it helps to uncover underlying unconscious conflicts that may be acting as triggers for the illness. In PDT, encouraging the patients to speak freely helps them understand the various factors contributing to their problem. It is also known as "insight-oriented therapy" wherein the therapist analyzes how a person's past affects his/her present thinking.<sup>35</sup>

CBT is a form of psychotherapy that examines how a person's beliefs and thoughts are linked to behavior and feelings. The therapist later retrains patients to modify their behavior and style of thinking, so as to help them deal with stressful situations.

Family and couples therapy is a form of joint therapy with other members of the family to help them work out their problems together. Family therapy could also be suggested, as it can increase compliance with treatment.<sup>36</sup>

## MEDICATIONS

Although no medication has been found to have dramatic or predictable effects, studies indicate that selective serotonin reuptake inhibitors (SSRIs) might help in reduction of depression, impulsivity, and affective lability as well as irritability and aggressive behavior.<sup>37</sup>

SSRIs in a higher dose range, similar to that used in patients with obsessive-compulsive disorder, have been found to be effective in the management of dermatitis artefacta. One study<sup>38</sup> showed a positive response in patients with dermatitis artefacta treated with high-dose sertraline (200 mg/d). In patients who are unresponsive to SSRIs, low-dose atypical antipsychotics may be added.<sup>33</sup>

## PROGNOSIS

With proper nursing care and an empathetic response from the doctor, the lesions of dermatitis artefacta heal well. However, the psychological management of such patients, especially those who have associated borderline personality disorders, is quite challenging. These patients need long-term care in the form of counseling as well as pharmacotherapy. Having considered all these factors, the prognosis of these patients was found to be poor in previous studies.<sup>6,8,10,14,30,35,39</sup>

## TAKE-HOME MESSAGE FOR PHYSICIANS

For patients with dermatitis artefacta, general physicians become the first point of contact with a health care worker. If psychological counseling is suggested prematurely, prior to establishing a good rapport with the patient, he/she will be lost to follow-up. Therefore, early identification of the condition, establishment of an empathetic bond with the patient, and timely referral for psychiatric intervention are important. This management approach can be made possible by creating awareness about the condition and by establishing liaison clinics with psychiatrists.



**It is illegal to post this copyrighted PDF on any website.**

**Submitted:** November 5, 2020; accepted December 8, 2020.

**Published online:** July 1, 2021.

**Potential conflicts of interest:** None.

**Funding/support:** None.

## REFERENCES

- Zalewska A, Kondras K, Narbutt J, et al. Dermatitis artefacta in a patient with paranoid syndrome. *Acta Dermatovenereol Alp Panonica Adriat*. 2007;16(1):37–39.
- Wong JW, Nguyen TV, Koo JY. Primary psychiatric conditions: dermatitis artefacta, trichotillomania and neurotic excoriations. *Indian J Dermatol*. 2013;58(1):44–48.
- Van Moffaert M, Vermader F, Kint A. Dermatitis artefacta. *Int J Dermatol*. 1985;24(4):236–238.
- Ikenaga S, Nakano H, Umegaki N, et al. A case of bullous dermatitis artefacta possibly induced by a deodorant spray. *J Dermatol*. 2006;33(1):40–42.
- Chatterjee SS, Mitra S. Dermatitis artefacta mimicking borderline personality disorder: sometimes, skin could be misleading. *Clin Psychopharmacol Neurosci*. 2016;14(3):311–313.
- Gattu S, Rashid RM, Khachemoune A. Self-induced skin lesions: a review of dermatitis artefacta. *Cutis*. 2009;84(5):247–251.
- Rogers M, Fairley M, Santhanam R. Artefactual skin disease in children and adolescents. *Australas J Dermatol*. 2001;42(4):264–270.
- Fabisch W. What is dermatitis artefacta? *Int J Dermatol*. 1981;20(6):427–428.
- Shelley WB. Dermatitis artefacta induced in a patient by one of her multiple personalities. *Br J Dermatol*. 1981;105(5):587–589.
- Mohandas P, Bewley A, Taylor R. Dermatitis artefacta and artefactual skin disease: the need for a psychodermatology multidisciplinary team to treat a difficult condition. *Br J Dermatol*. 2013;169(3):600–606.
- Lyell A. Cutaneous artifactual disease: a review, amplified by personal experience. *J Am Acad Dermatol*. 1979;1(5):391–407.
- Taylor S, Hyler SE. Update on factitious disorders. *Int J Psychiatry Med*. 1993;23(1):81–94.
- Nielsen K, Jeppesen M, Simmelsgaard L, et al. Self-inflicted skin diseases: a retrospective analysis of 57 patients with dermatitis artefacta seen in a dermatology department. *Acta Derm Venereol*. 2005;85(6):512–515.
- Sheppard NP, O'Loughlin S, Malone JP. Psychogenic skin disease: a review of 35 cases. *Br J Psychiatry*. 1986;149(5):636–643.
- Ehsani AH, Toosi S, Mirshams Shahshahani M, et al. Psycho-cutaneous disorders: an epidemiologic study. *J Eur Acad Dermatol Venereol*. 2009;23(8):945–947.
- Saez-de-Ocariz M, Orozco-Covarrubias L, Mora-Magaña I, et al. Dermatitis artefacta in pediatric patients: experience at the national institute of pediatrics. *Pediatr Dermatol*. 2004;21(3):205–211.
- Rodríguez Pichardo A, García Bravo B. Dermatitis artefacta: a review. *Actas Dermosifiliogr*. 2013;104(10):854–866.
- Kumaresan M, Rai R, Raj A. Dermatitis artefacta. *Indian Dermatol Online J*. 2012;3(2):141–143.
- Rodríguez-Pichardo A, Hoffner MV, García-Bravo B, et al. Dermatitis artefacta of the breast: a retrospective analysis of 27 patients (1976–2006). *J Eur Acad Dermatol Venereol*. 2010;24(3):270–274.
- Singh P, Jain A, Kar SK. Dermatitis artefacta: a consequence of self-injurious behavior during dissociative amnesia. *Medical Journal of Dr. D.Y. Patil Vidyapeeth*. 2017;10(2):217–218.
- Uçmak D, Harman M, Akkurt ZM. Dermatitis artefacta: a retrospective analysis. *Cutan Ocul Toxicol*. 2014;33(1):22–27.
- Harth W, Taube K-M, Gieler U. Factitious disorders in dermatology. *J Dtsch Dermatol Ges*. 2010;8(5):361–372, quiz 373.
- Lieb K, Zanarini MC, Schmahl C, et al. Borderline personality disorder. *Lancet*. 2004;364(9432):453–461.
- Gupta MA, Jarosz P, Gupta AK. Posttraumatic stress disorder (PTSD) and the dermatology patient. *Clin Dermatol*. 2017;35(3):260–266.
- Tamakuwala B, Shah P, Dave K, et al. Dermatitis artefacta. *Indian J Psychiatry*. 2005;47(4):233–234.
- Angus J, Affleck AG, Croft JC, et al. Dermatitis artefacta in a 12-year-old girl mimicking cutaneous T-cell lymphoma. *Pediatr Dermatol*. 2007;24(3):327–329.
- Harries MJ, McMullen E, Griffiths CEM. Pyoderma gangrenosum masquerading as dermatitis artefacta. *Arch Dermatol*. 2006;142(11):1509–1510.
- Koblentz C. Dermatitis Artefacta (Factitious Dermatitis, Including Factitious Ulcers). *Dermatology Advisor*. 2017. <https://www.dermatologyadvisor.com/home/decision-support-in-medicine/dermatology/dermatitis-arteacta-factitial-dermatitis-including-factitial-ulcers/>
- Sawant NS. Delusional parasitosis revisited. *Annals of Indian Psychiatry*. 2019;3(1):1–3.
- Saha A, Seth J, Gorai S, et al. Dermatitis artefacta, a review of five cases: a diagnostic and therapeutic challenge. *Indian J Dermatol*. 2015;60(6):613–615.
- Nayak S, Acharya B, Debi B, et al. Dermatitis artefacta. *Indian J Psychiatry*. 2013;55(2):189–191.
- Koblentz CS. Psychodermatology of women. *Clin Dermatol*. 1997;15(1):12–141.
- Koblentz CS. Neurotic excoriations and dermatitis artefacta. *Dermatol Clin*. 1996;14(3):447–455.
- Wojewoda K, Brenner J, Kąkol M, et al. A cry for help, do not omit the signs: dermatitis artefacta—psychiatric problems in dermatological diseases (a review of 5 cases). *Med Sci Monit*. 2012;18(10):CS85–CS89.
- Tomas-Aragones L, Consoli SM, Consoli SG, et al. Self-inflicted lesions in dermatology: a management and therapeutic approach - a position paper from the European Society for Dermatology and Psychiatry. *Acta Derm Venereol*. 2017;97(2):159–172.
- Counselling and Psychotherapy. NHS Inform. Cited October 27, 2020. <https://www.nhsinform.scot/tests-and-treatments/counselling-and-therapies/counselling-and-psychotherapy>
- Hollander E, Swann AC, Coccaro EF, et al. Impact of trait impulsivity and state aggression on divalproex versus placebo response in borderline personality disorder. *Am J Psychiatry*. 2005;162(3):621–624.
- Koparde V, Patil S, Patil S. Dermatitis artefacta (factitious dermatitis) responding to high-dose sertraline. *Journal of Mental Health and Human Behavior*. 2018;23(1):67–68.
- Kibel HD. The importance of a comprehensive clinical diagnosis for group psychotherapy of borderline and narcissistic patients. *Int J Group Psychother*. 1980;30(4):427–440.

You are prohibited from making this PDF publicly available.