Late-Onset Dermatillomania in Profound Intellectual Disability

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Excoriation (skin-picking) disorder, also referred to as dermatillomania, psychogenic excoriation, or neurotic excoriation, is characterized by recurrent and compulsive picking of the skin, resulting in dermal lesions and considerable distress or functional impairment.[1] Although skin picking is relatively prevalent, with estimates of excoriation disorder ranging between 1.4% and 5.4%[2,3] in the general population, a heightened prevalence is observed among individuals with developmental disabilities, such as Prader-Willi syndrome and Smith-Magenis syndrome.[4,5] However, the documentation of late-onset dermatillomania in adults with profound intellectual disability remains scant in the literature, presenting unique clinical challenges that are seldom addressed.

The diagnostic criteria delineated in the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (*DSM-5*), encompass recurrent skin picking resulting in lesions, unsuccessful attempts to cease the behavior, significant functional impairment, and the exclusion of substance-related effects or other medical/psychiatric disorders.[1] However, the application of these criteria in individuals with profound intellectual disability necessitates substantial modifications due to communication barriers and pronounced behavioral challenges. Consequently, this case report elucidates critical deficiencies in the existing literature by documenting late-onset dermatillomania in a 39-year-old woman with profound intellectual disability (IQ of 34), discussing the adaptations required for assessment, and demonstrating the efficacy of treatment within this particularly challenging demographic.

Case Report

A 39-year-old unmarried woman from a rural background, with profound intellectual disability (IQ of 34 per the Vineland Social Maturity Scale,[6] assessed 4 years prior) and delayed developmental milestones, presented with severe dermatillomania. At the age of 37 years, the patient manifested excessive behaviors of skin scratching and picking on her hands and legs, which constitute a late-onset presentation that is atypical for this demographic. Initially precipitated by irritability during conflicts with her parents or when her demands were unmet, the behavior subsequently evolved to become independent of external stressors. The patient exhibited a consistent pattern: initiating wounds with sharp implements, followed by a systematic expansion of these wounds through meticulous picking at their edges, culminating in characteristic linear lesions extending up to 30 cm in length. This methodical approach implies a retention of procedural learning capabilities despite profound cognitive impairment.

There were no other complaints such as persistent sadness of mood, ideas of helplessness and worthlessness, hearing unseen voices, muttering to self, or gesticulating behavior. There was no history of substance abuse or dependence, nor was she receiving any pharmacologic treatment. Furthermore, there were no disturbances in sleep or appetite. A familial history of psychiatric disorders was absent. The patient presented with no other medical or surgical conditions. Upon general and systemic examinations, no significant abnormalities were noted, aside from numerous healing and healed scars located on the bilateral legs and forearms, with the most prominent active wound measuring approximately 30 cm in a linear configuration on the right shin. This systematic linear pattern distinguishes it from the typical self-injurious behaviors observed in individuals with intellectual disabilities.

On mental status examination, eye contact was initiated but not maintained throughout the assessment period. The patient appeared shy in expressing her feelings initially, displaying a palpable hesitance. Limited verbal expression required reliance on caregiver reports and behavioral observation to gain insights into her emotional state. She was noncooperative during a detailed cognitive assessment and an extensive psychiatric evaluation, further complicating the assessment process. Her mood was dysphoric, marked by an appropriate demeanor but exhibiting a restricted affect and notable shyness in emotional expression.

The patient was diagnosed with an intellectual disability and excoriation disorder in accordance with the modified *DSM-5* criteria application:

1. Recurrent skin picking: verified through direct observation and caregiver testimonies.
2. Unsuccessful cessation attempts: evaluated through the failure of behavioral interventions.
3. Functional impairment: documented through social withdrawal and associated medical complications.
4. Exclusion criteria: excluded following a comprehensive

medical evaluation and psychiatric assessment.

Initial interventions began with behavioral modifications and environmental controls; however, these proved inadequate, necessitating the consideration of pharmacologic intervention. Given the lack of response, pharmacotherapy was deemed appropriate. She was initiated on fluoxetine at a dosage of 20 mg, alongside aripiprazole 2 mg and clobazam 5 mg. Within 2 weeks, her symptoms of anxiety and irritability diminished. There was minimal improvement in the skin-picking behavior after 4 weeks, and no significant change was observed in this regard. Consequently, at the subsequent follow-up, the dosage of fluoxetine was increased to 40 mg. All other medications were also continued. A gradual improvement was noted thereafter. Remarkably, she completely stopped the infliction of wounds and skin picking within 4 weeks of the dosage increase, a positive outcome that was maintained at the 3-month follow-up.

Discussion

Dermatillomania typically presents in adolescence, making this late-onset adult presentation in profound intellectual disability particularly noteworthy. Adult-onset dermatillomania is atypical, as most cases associated with intellectual disability typically begin in childhood or adolescence. Furthermore, the retention of procedural learning, despite profound intellectual disability, manifested through methodical wound creation, underscores the distinctive nature of this case. Lastly, the modification of assessment techniques to establish a diagnosis—predominantly relying on caregiver reports and behavioral observations—represents an approach not previously documented.

Skin-picking disorder has historically been categorized as an impulse-control disorder not otherwise specified, a stereotypic movement disorder, an obsessive-compulsive disorder, a behavioral addiction, and a form of self-injurious behavior. The *DSM-5* has distinctly classified it within the chapter dedicated to obsessive-compulsive and related disorders.[1] This condition is characterized by recurrent picking of one's own skin, with the onset typically occurring during adolescence, although it may manifest at any age. The most frequently targeted areas include the face, hands, fingers, arms, and legs; however, individuals may also pick, squeeze, or rub various regions, often focusing on healthy skin or minor skin irregularities.[7] Some individuals report experiencing an overwhelming urge to pick, which is alleviated by engaging in skin picking, while others may perform the act automatically, lacking full awareness of their behavior.[8] The prevalent psychological consequences of skin picking include social embarrassment, avoidance behavior, and diminished productivity across multiple settings.[9] Common medical repercussions encompass infections at the site of picking, scarring, and physical disfigurement. Additionally, other body-focused repetitive behaviors, such as trichotillomania, obsessive-compulsive disorder, and body dysmorphic disorder, frequently co-occur with this condition.

Individuals grappling with emotional distress often exhibit skin-picking behaviors as a response to this turmoil. A systematic review of behavioral interventions for chronic skin picking in individuals with developmental disabilities posits that internal states, such as heightened arousal, may precipitate skin-picking episodes, which, in turn, may serve to mitigate or alleviate these distressing states.[10] This theoretical framework suggests a particular treatment approach. When a comorbid psychiatric condition, such as an anxiety disorder, is identified, it may prove more efficacious to prioritize treatment for that condition rather than solely addressing the skin-picking behavior. Consequently, skin picking may be symptomatic of an underlying psychiatric issue that necessitates intervention. In this instance, the treatment strategy adhered to this principle; we initially focused on alleviating the underlying triggering symptoms, such as irritability, apprehension, and dysphoria, exhibited by the patient before addressing the repetitive behavior.

Drugs classified as selective serotonin reuptake inhibitors (SSRIs) have demonstrated efficacy in ameliorating skin-picking behaviors associated with excoriation disorders. Notably, 2 studies employing fluoxetine utilized flexible dosing regimens of up to 80 mg/day for a duration of 10 weeks or 60 mg/day for 6 weeks.[11,12] Patients may experience embarrassment when disclosing areas of the skin that have become infected or exhibit severe manifestations. A thorough physical examination is imperative to accurately assess both the extent and severity of the skin picking. Arnold et al conducted a comprehensive review of 18 studies focusing on the pharmacologic treatment of skin picking and concluded that SSRIs, along with doxepin, clomipramine, naltrexone, pimozide, and olanzapine, may be effective in mitigating skin-picking behaviors.[13] In our case, the skin picking exhibited a favorable response to fluoxetine. Nonetheless, the necessity for higher initial dosages to achieve an optimal therapeutic response may be warranted in individuals with intellectual disabilities; however, vigilant monitoring for adverse effects is essential, particularly given the communication challenges that may arise.

Conclusion

This case represents, to our knowledge, the first documented account of late-onset dermatillomania in an adult with profound intellectual disability, thereby addressing a significant gap in the clinical literature. The distinctive presentation challenges conventional diagnostic paradigms and underscores the necessity for tailored

assessment strategies within this demographic. The successful treatment outcome illustrates that, with appropriate modifications to both assessment and therapeutic approaches, individuals with profound intellectual disability and dermatillomania can attain complete remission, markedly enhancing the quality of life for both patients and caregivers.

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