# Self-inflicted Skin Lesions: A Review of the Terminology

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**SUMMARY** The current literature on the management of self-inflicted skin lesions points to an overall paucity of treatments with a high level of evidence (randomized controlled trials, controlled trials, or meta-analyses). In order to improve the communication between dermatologists and mental health professionals, the European Society for Dermatology and Psychiatry (ESDaP) recently proposed a classification of psychodermatological terms in order to establish a coherent use of terms across the medical fields involved.
We reviewed current and previous psychodermatological diagnoses in order to clarify how the previous plethora of terms is covered by the new classification.
This may aid physicians and mental health professionals in understanding how the new classification relates to the prior plethora of psychodermatological diagnoses and thereby facilitate the future use of the new classification.

**KEY WORDS:** terminology, psychodermatology, self-inflicted skin lesions

## INTRODUCTION

The terminology within the field of psychodermatology is currently the subject of much debate due to an abundance of confusing and often contradictory terms. This may impede the management of these diseases, as the treatment is often a multidisciplinary cooperation between dermatologists and mental health professionals where clarity and consistency in terminology is essential. Furthermore, the many confusing terms referring to the same few conditions may complicate the dissemination of important knowledge. In keeping with this, a recent survey study of dermatologists demonstrated that only a small minority among the responders felt they had a clear understanding of the field of psychodermatology and the conditions that fall under it (1).

Realizing the need for a coherent use of terminology across the medical disciplines involved, the European Society for Dermatology and Psychiatry (ESDaP) recently proposed a classification of psychodermatological conditions (2).

In order to facilitate an optimized understanding of the proposed terminology, we have reviewed the previous and current utilization of the psychodermatological terminology.

This may aid physicians and mental health professionals in understanding how this new classification relates to the earler plethora of psychodermatological diagnoses and may facilitate the future use of the new classification.

The following is a brief introduction to the recently proposed classification of diagnoses by ESDaP.

Factitious disorder in dermatology (FD) has been defined as a set of faked or self inflicted skin lesions created without clear external incentives. Comorbidity of psychiatric origin is often present in these patients (e.g. anxiety or depression) and a majority of the patients may at first not acknowledge their role in the creation of the lesions due to possible dissociative episodes. Furthermore, as in Münchausen syndrome,

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**Table 1.** Overview of the abundant psychodermatological terminology seen in relation to the recent recommendations from ESDaP

| ESDaP recommendations | Synonyms used | Notes |
|---|---|---|
| Factitious disorder in dermatology | Dermatitis artefacta (7)<br>Factitial dermatitis (26)<br>Self-induced factitial dermatitis (27)<br>Facticial dermatitis (28)<br>Dermatitis factitia (28)<br>Artefactual skin disease (9)<br>Factitious illness (11)<br>Illness falsification (11)<br>Dermatological pathomimicry (12)<br>Cutaneous artefactual disease (8)<br>Dermatitis simulata (29)<br>Factitious skin disease (30) | Several inconsistencies regarding the definition |
| Skin-picking syndrome | Neurotic excoriation (16)<br>Dermatillomania (16)<br>Psychogenic excoriation (16)<br>Compulsive skin picking (2)<br>Pathologic skin picking (31)<br>Skin picking disorder (32)<br>Dermatitis para-artefacta (2)<br>Self-injurious skin picking (33)<br>Repetitive skin picking (33)<br>Emotional excoriations (34)<br>Nervous scratching artefact (34)<br>Paraartificial excoriations (34)<br>Epidermatillomania (34)<br>Acne urticata (34) | The recommended term encompasses both the compulsive and the impulsive spectrum |
| Rhinotillexomania | Pathological nose picking (2)<br>Compulsive nose picking (35) | |
| Dermatillomania | Psychogenic excoriations (16)<br>Neurotic excoriations (16)<br>Skin picking syndrome (16)<br>Excoriation (17) | |
| Acne excoriée | | No synonyms identified |
| Trichotillomania | Neuromechanical alopecia (17)<br>Hair pulling disorder(32)<br>Pathologic hair pulling (36) | |
| Trichophagia | Trichorrhizophagia (37) | The term was coined to describe patients who exclusively eat the root of the hair. |
| Trichoteiromania | | No synonyms identified |
| Trichotemnomania | | N0 synonyms identified |
| Onychophagia | Pathological nail biting (36) | |
| Self inflicted cheilitis | Cheilitis factitia (2)<br>Facticial cheilitis (38)<br>Factitious cheilitis (39)<br>Factitious lip crusting (40) | |
| Morsicatio buccarum | | No synonyms identified |
| Malingering in dermatology | Dermatitis artefacta (13-15) | The term has been misinterpreted as *dermatitis artefacta* |
| Delusional infestation | Delusional parasitosis (41)<br>Psychogenic parasitosis (42)<br>Ekboms syndrome (43)<br>Pseudoparasitic dysaesthesia (17)<br>Delusions of parasitosis (44)<br>Parasitic dermatophobia (45)<br>Parasitophobia (45)<br>Entomophobia (45)<br>Acarophobia (45) | Delusional infestation may fall outside the scope of SISL |

these patients are assumed to have a preference for the patient's role (3). However, in Münchausen syndrome patients feign an acute disease with exaggerated, overly-dramatized symptoms and give a false medical history. Although self-inflicted skin lesions may be a part of the syndrome, these patients present a generally more flamboyant clinical picture and often move between hospitals (4).

"Malingering" is a broad term that refers to feigning or production of illness for fraudulent purposes. In dermatology this often takes the form of self inflicted skin lesions inflicted while fully aware, with the objective of achieving apparent advantages such as financial gain or exemption from work. The common denominator between malingering and factitious disorders is that the infliction of skin lesions occurs in secrecy, though the motivation for self-mutilation differs (3).

In striking contrast to both FD and malingering, patients with skin picking syndrome do not have any fraudulent purposes or other definite aims, and are fully aware of having caused the lesions themselves. The syndrome encompasses both the impulsive and compulsive spectrum (2). Compulsive skin damaging is a repetitive form of self mutilation where the patients may experience a sensation of relief through their self-inflicting behavior, and attempts to manage or control the urge often results in increased tension (e.g. trichotillomania or acne excoriê) (5).

Impulsive skin picking is often found among borderline patients and appears to be provoked by a situation with intractable emotional circumstances. The mutilation is considered to be the patient's way of coping with stressful situations, as it may provide a short-lived relief from the emotional disarray (6).

## METHOD

We reviewed psychodermatological articles and investigated the use of the terminology and diagnostic classification of self-inflicted skin lesions (SISL). PubMed, Embase, and PsychINFO databases were systematically searched. The research applied different combinations of Medical Subject Headings (MeSH): "Self injury, behaviour AND (factitious disorders OR malingering OR Münchausen OR skin picking syndrome)". We limited the literature search to articles written in English, Danish, Norwegian, Swedish, or French. We placed no restrictions in terms of year of publication.

Since several psychodermatological terms do not exist as a MeSH terms, we also performed a free-text search on various terms e.g. "dermatitis artefacta", "psychogenic excoriation" and "artefactual skin disease" in PubMed, and then retrieved further references from the related articles.

## DISCUSSION

As attested to by the literature, it is evident that dermatitis artefacta is by far the most frequently applied synonym for factitious disorder in dermatology (7). However, the term "dermatitis artefacta" seems somewhat misleading, as it suggests an underlying inflammation which is not necessarily present in self-inflicted lesions. This has also been noted by several authors, and Lyell (8) and Roger *et al.* (9) addressed these "term-issues" and instead suggested "cutaneous artefactual disease" and "artefactual skin disease", respectively (Table 1). Furthermore, there also appear to be remarkable inconsistencies regarding the definition. It seems to derive from a disagreement on whether the self-infliction is carried out in full awareness or not. This is noteworthy as there is a widespread consensus on the fact that these patients may dissociate from the self-inflicting episode. Disagreements on the extent to which these patients benefit from their self inflicting behavior have also arisen. Authors have stated that these patients may harm themselves in order to escape responsibility or to collect disability insurance (10). This is a striking misinterpretation of the term, since patients suffering from a factitious disorder do not have any immediate tangible benefits. The term "factitious" is also used in describing other self-inflicted disorders, e.g. factitious cheilitis, and its justification in this context is questionable. In this context, the term "factitious" appears somewhat confusing as the lesions are neither denied nor hidden by the patient.

Illness falsification and factitious illness have been used synonymously, with factitious disorder referring to intentional fabrication of diseases (e.g. fever or purpura) in all the medical disciplines (11). Along with malingering, dermatological pathomimicry has also been used in the context of factitious disorders in dermatology. The condition refers to the induction of lesions mimicking features of well-recognized dermatological disorders. The initial description of the term from Millard stated, however, that one should not confuse the term with "dermatitis artefacta" (12).

Unlike factitious disorder in dermatology, malingering appears to have been used in dermatology without various synonyms although it may be confused with the much less used "pathomimicry". Unfortunately, within the spectrum of SISL the term "malingering" has not seen as widespread use as one could have hoped for. There are several examples in the literature of articles describing self-inflicted skin

lesions in soldiers seeking exemption from military duty without mention of malingering and with using the term dermatitis artefacta (factitious disorder in dermatology) applied erroneously instead (13-15).

Skin picking syndrome encompasses both the compulsive and the impulsive spectrum. The term skin picking itself has been used synonymously with disorders such as neurotic excoriations, dermatillomania, or psychogenic excoriations (16). It has been noted that the synonyms may be considered pejorative and stigmatizing, and thus some authors discourage the use of these terms (17).

The nomenclature in compulsive skin picking disorders and related skin damaging syndromes appears to have a vast array of synonyms, although this is not applicable to every compulsive disorder (e.g. acne excoriê). Even though ESDaP recommends the use of the term "trichotillomania", that term has been used inconsistently, and authors have advocated its replacement with "neuromechanical alopecia" as they find "mania" stigmatizing (17). Nonetheless, "trichotillomania" appears to be the most widely applied term in dermatology, and thus it is also the preferred term according the ESDaP authors.

One may speculate whether all psychodermatologic diseases have their place within the spectrum of self-inflicted skin lesions (SISL), this being particularly debatable for delusional infestation (DI) due to its psychiatric nature. Patients with delusional infestation are convinced that they are infected with various organisms (e.g. parasites, bacteria, or viruses) often leading to self inflicted excoriations of the skin (18). Although the term may fall outside the strict sense of SISL, the patients may still constitute a perplexing issue viewed from a dermatological perspective. The term "delusional infestation" has been frequently used, with "delusional parasitosis" (DP) as the most common synonym. However, it has been noted that "delusional parasitosis" does not cover patients convinced that they are infected with species other than parasites, therefore the term appears inadequate as it does not cover the whole spectrum of possible "intrusive" pathogens (19). In contrast, "delusional infestation" is an all-encompassing term as it covers all possible species. The common denominator between DI and DP is the use of the term "delusional" which appears preferable to e.g. "parastiophobia" as the patients have a fixed false belief (delusion) and not a phobia. Furthermore, authors have stressed that that the term "delusional" may potentially be interpreted as degrading and have attempted to rename the disorder to "pseudoparasitic dysaesthesia" (17).

Münchausen syndrome was first introduced by Asher in 1951 (20) and its definition has scarcely changed since then (21). The syndrome is akin to factitious disorder but is distinguished by its extreme presentation and more refractory illness (22). Three characteristic features define Münchausen syndrome: 1) factitious symptoms, 2) hospital or doctor "shopping", and 3) pseudologia phantastica (pathological lying characterized by wildly exaggerated stories) (2,22). Some argue that these criteria are inherently difficult to operationalize, and should therefore be abandoned in favor of the broader term factitious disorder (23). Indeed, the syndrome was removed from the DSM classification by the fourth version, though it still sees widespread use in published articles and letters (24).

Lastly, it should be noted that the term "Münchausen syndrome" is preferable to "Münchausen's syndrome", the preference for the non-possessive form being due to the fact that Munchausen has no proprietary claim on the entity (25).

## CONCLUSION

The current literature available on the management of self-inflicted skin lesions points to an overall paucity of treatments supported by a high level of evidence (randomized controlled trials, controlled trials, or meta-analyses). Our overview of the abundant psycho-dermatological terminology seen in relation to the recent recommendations from ESDaP may contribute to the necessary framework for future therapeutic trials leading to the development of evidence based guidelines. This may optimize the multidisciplinary cooperation between the medical fields involved, which is considered crucial in the management of psychocutaneous disorders.

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