

Medical Assessment and Management of Skin-picking and Scratching Self Injurious Behavior (SIB) in the Person with Mental Retardation and Developmental Disabilities (MR/DD)

1. Overview

Skin-picking and scratching can be a significant clinical problem in the person with DD/MR. Scratching or picking can progress to the point where the patient has wound infections, scars, and other injuries. The first step in management of picking or scratching is a careful assessment to exclude physical causes for the behavior (1), (2).

Skin-picking may be a behavioral response to boredom, fear, anxiety or stress produced by environmental demands. A behavioral assessment is required to exclude behavioral causes.

The clinician should begin by considering the skin region that is picked or scratched to determine potential etiologies. Picking or skin gouging over the face or head may be distinct from the extremities or abdomen or the perineal region. Each anatomical region has a unique differential diagnosis that requires careful consideration (See Table 1).

Table 1
Differential Diagnosis of Skin-Picking

General

- Pain
- Boredom
- Allergic dermatitis
- Scabies

Facial

- Dental pain
- Oral disease

Perineal

- Rectal or vaginal discomforts
- Impaction

2. Diagnosis

Skin-picking or scratching at any location may suggest allergic dermatitis, dry skin or some other dermatological disorder that produce pruritis and itching. The patient should be referred to a dermatologist who has some familiarity with persons with mental retardation. The areas of excoriation and picking should be carefully examined to exclude allergic dermatitis, psoriasis, scabies, skin infections, or other potential causes of skin discomfort. Skin-picking or scratching over the head or neck may be produced by head discomfort (See Handout on Head-related SIB). Digging on the extremities could represent discomfort in the bones or joints beneath the skin. Digging over the abdominal thorax could represent a response to abdominal discomfort. Certain types of

liver disease, including hepatitis, can produce pruritis and these individuals may manifest digging or scratching over their abdominal area. Skin-digging in the rectal or perineal area could represent rectal digging or fecal smearing (See Fecal Smearing Handout). Laboratory evaluation could include liver function studies, CBC with differential and stool for ova and parasites depending on the clinical circumstances.

Tactile hallucinations are uncommon in all clinical settings except for delirium or drug intoxication, such as amphetamines. Tactile hallucinations are an uncommon form of pre-ictal symptomology in seizure disorders. The frequency and manifestations of picking behavior such as trichotilloma is not described in the literature; however, it can occur in people with intellectual disability.

3. Treatment

The medical and psychiatric team may consider empirical trials of oral anti-pruritic medications or topical agents to assess the possibility of allergic dermatitis. A two-week course of Tylenol on a regular basis can be tried when pain is suspected. Antihistamines, which may produce confusion or delirium, should be avoided.

Patients with a past history of depression or anxiety should be considered for pharmacological therapy to exclude the possibility that psychiatric morbidity is promoting this form of SIB **(3), (4)**.

Antipsychotics and benzodiazepines should be avoided in the management of this symptom unless sedation is the only method to suppress self-injurious behavior. Although Pimozide has been discussed as an effective agent for parasitosis, this agent has many side effects and limited tolerability by the mentally retarded person. Anticonvulsants and mood stabilizing agents are not effective for this disorder.

4. Behavioral Intervention

The treatment of choice for skin picking is behavioral management. Boredom, anxiety, or escape behavior can be managed through behavioral intervention.

5. Conclusion

Skin-picking, pinching, and digging are often the result of boredom and this form of self-stimulation can be reduced through proper behavioral interventions. Each patient should have a meticulous behavioral assessment prior to the use of pharmacological agents and behavioral interventions should be proven ineffective prior to use of drugs for sedation.

REFERENCES:

1. Kastner T, Walsh KK, Fraser M. Undiagnosed medical conditions and medication side effects presenting as behavioral/psychiatric problems in people with mental retardation. *Mental Health Aspects of Developmental Disabilities*, July/August/September 2001;4(3):101-107.
2. Ryan R, Sunada K. Medical evaluation of persons with mental retardation referred for psychiatric assessment. *General Hospital Psychiatry* 1997;19:274-280.
3. Ricketts RW, Goza AB, Ellis CR, et al. Fluoxetine treatment of severe self-injury in young adults with mental retardation. *J Am Acad. Child Adolesc. Psychiatry* 1993;32(4):865-869.
4. Special Issue. Expert Consensus Guidelines Series: Treatment of psychiatric and behavioral problems in mental retardation. *American Journal on Mental Retardation* 2000;105(3):165-188.