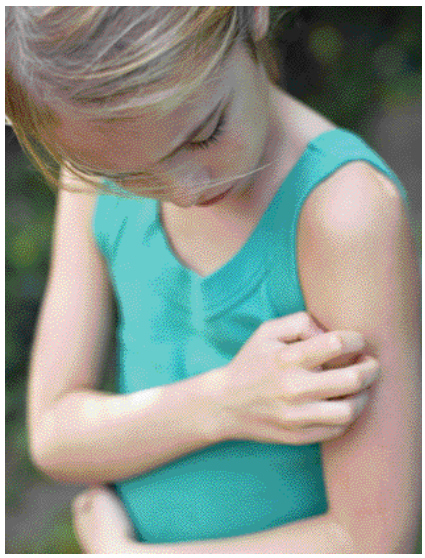
A 7-year-old girl scratching holes in herself

COMMENTARY BY **JEANIE SHEFFIELD** BA(Hons), PhD(Clinical)

Cognitive behavioural therapy is an effective way to control OCD-type behaviour and focus the patient's attention away from the need to scratch.



PHOTOLIBRARY

Case scenario

Emma is aged 7 years and lives with her mother and stepfather and her adored baby sister. She spends most weekends with her father who has moved back into the home of his elderly parents. Emma's mother brought her in to the surgery and confided that she was at her wit's end because Emma was recurrently scratching holes in herself.

It appeared that a kind of ritual had developed where Emma started to rub a small area of her skin harder and harder until she was able to penetrate the skin with her fingernail and dig out a small lump of flesh. She had about seven or eight scabbed holes on her trunk and limbs and even a couple medial to her scapula, where she hoped her mother wouldn't see.

Emma said that she tried not to do it but that she couldn't stop thinking about it. She initially said that a voice was telling her to do it. She appeared to be a very self-possessed little girl who was happy at school and had lots of friends.

What help can Emma be offered to overcome this problem?

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Commentary

Emma was referred to a clinical child psychologist after a consultation with her GP failed to find any organic causes for the symptoms that she is displaying. Scratching and picking the skin to the point of creating holes could reflect atopic dermatitis, parasitic infestation or a rare systemic illness. Once these have been ruled out, then the possibility of a developmental delay disorder should be explored.

A feature of developmental delay disorders is the higher likelihood of stereotypical behaviours, such as the flapping and rocking seen in autism spectrum disorders. Given that Emma is attending a mainstream school and seems to be functioning well in this setting, developmental delay is less likely to be a diagnosis. Corroborating evidence should be sought from Emma's mother to determine if all major developmental milestones were met. If organic and developmental causes do not explain the symptoms, then psychological causes may provide a better explanation.

Some of the interesting features of this case are the compulsive nature of Emma's picking, her trying to hide some of the wound sites and her initial statement that a voice was telling her to pick her skin. It is important to note that the skin picking appears to be more enduring and severe than the mild self-limiting picking that young children may engage in. In addition, Emma's current family situation warrants further investigation.

The recurrent scratching and the sense of compulsion to engage in the scratching and picking behaviours show strong similarity to an impulse control disorder, such as trichotillomania,[1] or a body-focused repetitive behaviour, such as nail biting. Although not a recognised *DSM*-IV disorder, compulsive skin picking is also known as pathological skin picking, psychogenic excoriation or dermatillomania. It is defined as the compulsive picking of the skin to the extent of causing tissue damage. Picking can occur on the face or any part of the body.

Little is known about the onset or prevalence of compulsive skin picking in the general population; however, onset appears to be more common during adolescence or early adulthood with a recent study reporting a median age of onset of 12 years.[2] Skin picking is more common in females than in males.

The sense of compulsion to engage in the scratching behaviour and the inability to stop thinking about it further suggests that it shares some features consistent with an anxiety disorder, such as obsessive-compulsive disorder (OCD) or symptoms of anxiety not present at a level sufficient to make a clinical diagnosis. The ritualised recurrent scratching and the sense of compulsion to engage in the behaviour may also represent some form of emotional

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regulation. Finally, the behaviour may represent underlying symptoms of depression or adjustment difficulties to some troubling situation or aspect of the patient's environment.

Assessment

There are a few key areas of Emma's case that should be assessed further, specifically about the topography of the scratching and picking (for example, frequency, duration and conditions under which it occurs most frequently). The possible function of the behaviour (for example, the precipitants and consequences) should also be assessed. This will help treatment planning because it may provide some suggestions for alternative behaviours or strategies that could be employed by Emma to achieve the same outcome in a more adaptive manner. The voice that Emma has reported hearing should be explored and whether it is still a current symptom.

The current family situation should be explored in greater depth, asking for details about:

- the length of time since parental separation
- how long they have lived as a 'blended' family and Emma's relationship with her stepfather
- the arrival of the adored baby sister and Emma's reaction to her arrival
- the amount of time and attention the mother is able to give to Emma
- the father's current situation and the reasons he is living with his elderly parents (for example, financial difficulties for him or health issues for his parents)
- the relationship between Emma's father and mother
- Emma's relationship with her father and grandparents
- Emma's mood and behaviour after access visits with her father.

Initially the situation should be discussed with Emma's mother as the source of the initial referral, then with the mother and Emma together. Finally, the situation should be discussed with Emma by herself to allow her to provide her perspective on the situation and to assess any current worries or anxieties she may have. Given the number of life changes that have occurred for both Emma and her family as a whole (for example, family breakdown, reconstituted family, addition of a new sibling and recently starting school), it is possible that Emma has interpreted the events and her role in them in a way that may be contributing to her difficulties. For example, if she believes that she caused her parent's break up or that she has been replaced by her baby sister in her mother's affection she may feel guilty, anxious or sad. The picking behaviour may be an attempt to regulate her negative emotions.

Starting date: _____

Behaviour: *Scratching/picking skin*

X = Behaviour occurred at least once in that time period

Time of day in 30-minute intervals	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
7.00 to 7.30	X	X		X	X	X	X
7.30 to 8.00	X		X		X		X
8.00 to 8.30	X	X	X	X	X	X	X
8.30 to 9.00							
9.00 to 9.30		X		X		X	X

etc.

Figure. Sample monitoring form.

Monitoring

As part of the assessment of the features of the scratching, Emma's mother could be asked to monitor the scratching behaviours using a time sample record with the day broken into 30-minute time blocks (Figure). She would be asked to record the presence of scratching behaviour if it occurs once or more in the specified time block. This will identify times of the day when Emma is scratching and then an examination can take place to find out what else may be occurring at the same time as the scratching.

Treatment

There are two possible treatment approaches that seem most suitable given the features of Emma's case. The first approach that would target the symptoms displayed by Emma is cognitive behavioural therapy (CBT). CBT is the treatment of choice for any impulse control disorder, OCD, anxiety or adjustment problems. CBT uses a combination of psychoeducation, rehearsal, graded exposure, relaxation training, cognitive training, positive 'self talk' and coping strategies.

Given Emma's age, the CBT will need to be tailored to make it suitable for her development and level of understanding. This can be achieved with a simple explanation of her current situation using appropriate language, behavioural activities and the use of brave role models to cope with anxiety-provoking situations.

If OCD-type symptoms are prominent, the picking behaviour could be targeted through exposure and response prevention. Emma would be asked to imagine or engage in the anxiety-provoking situations that currently lead to picking. She would then be assisted to refrain from picking and scratching until her anxiety levels

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reduced to below the starting level. With repeated exposures she should habituate to the anxiety-provoking situations until they no longer provoke anxiety.

The second approach that could be employed if the picking is more consistent with body-focused repetitive behaviour is habit reversal training (for example, awareness training and competing response training). Emma would first be helped to identify when she is picking and scratching, and then provided with a competing response, such as clasping her hands, folding her arms or even sitting with her hands under her thighs, to perform instead. Throughout treatment Emma would also be helped to develop simple coping strategies and generate brave statements that she can say to herself when encountering difficult situations.

Although the suggested CBT approach focuses on Emma and her problems, it may also be clinically useful to support this with some family therapy given her current family situation. Goals of this therapy would be to talk to Emma's mother, father and stepfather, the major adults in her life, about the current situation and assist them to provide a safe and predictable environment for Emma.

Some simple positive parenting strategies to provide appropriate attention to Emma could be provided for the adults with the key aim of providing a consistent and standard message when parenting Emma. They would also be advised of the individual treatment for Emma and enlisted to help her to implement homework activities, to encourage brave behaviour in anxiety-provoking situations and to discourage avoidance or inappropriate coping.

Monitoring by Emma's family and Emma herself would be a vital element of these treatment approaches to track changes in behaviours and provide confirming evidence for correct or helpful thoughts. CBT is not usually a long treatment and the family therapy would be applied conjointly. I would expect any response to occur within eight to 12 sessions, with the option of a further one or two 'booster' sessions after treatment to ensure treatment gains are maintained. MT

References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. Text revision. 4th ed. Washington DC: American Psychiatric Association; 2000.
2. Flessner CA, Woods DW. Phenomenological characteristics, social problems and the economic impact associated with chronic skin picking. Behav Modif 2006; 30: 944-963.

COMPETING INTERESTS: None.

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