



LETTER TO THE EDITOR

Skin picking disorder among adult psychiatric inpatients

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Dear Editor,

Skin-picking disorder (SPD) (excoriation disorder/dermatillomania) is a body-focused repetitive behavior characterized by recurrent skin picking resulting in excoriations, erosions, and sometimes ulcerations with secondary scarring, accompanied by distress and functional impairment. SPD is classified within the obsessive-compulsive and related disorders chapter in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) (1). Population-based studies have reported SPD prevalence estimates ranging from approximately 1.4% to 3.4% (2–4). However, data on SPD specifically within psychiatric inpatient settings remain limited. In these settings, symptoms that are not the primary reason for admission may be overlooked unless specifically assessed. Given potential underrecognition, impaired insight, and overlapping psychopathology in severe mental illness, investigating SPD in inpatient settings is clinically relevant. Accordingly, we aimed to describe the frequency and clinical characteristics of SPD detected through a joint dermatologist–psychiatrist evaluation among adult psychiatric inpatients.

Between February and August 2025, adult inpatients (≥ 18 years) hospitalized at Bakirkoy Prof. Mazhar Osman Training and Research Hospital were evaluated. All adult patients admitted to two different

general psychiatry wards during the study period were approached consecutively. The study was approved by Bakirkoy Dr.Sadi Konuk Training and Research Hospital Clinical Research Ethics Committee (decision number: 2024-08-04; date: 19.08.2024). Written informed consent was obtained from all participants. Each patient underwent a joint clinical assessment by a dermatologist and a psychiatrist. Psychiatric diagnoses were established according to DSM-5-TR criteria, and the diagnosis of SPD was determined by a psychiatrist based on DSM-5-TR diagnostic criteria. A total of 186 patients were assessed, including 73 women; the mean age was 38.6 ± 12.9 years. SPD was identified in 13 of 186 inpatients (7.0%); only two of these patients had a documented SPD diagnosis prior to the study. The demographic and clinical characteristics of the cases, including psychiatric diagnoses, active psychoactive substance use status, duration of SPD, history of suicide attempt, prior dermatology visit, and main sites of involvement, are summarized in Table 1.

Our inpatient prevalence (7.0%) is higher than estimates from community studies (current $\sim 2.1\%$; lifetime $\sim 3.1\%$) and pooled prevalence across epidemiologic studies ($\sim 3.45\%$), yet comparable to rates reported in acute psychiatric samples (e.g., 9% in a partial hospital sample) (5) and consistent with reports that skin picking may be enriched in psychiatric inpatient settings (11.8% among adolescent inpatients) (5, 6).

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Table 1: Case series summary of skin-picking disorder in adult psychiatric inpatients

No	Age/ Sex	Primary psychiatric diagnosis (admission)	Substance use	History of suicide attempt	Duration of SPD (years)	Prior dermatology visit	Main sites involved
1	43/M	Schizophrenia	No	No	4	No	Arms
2	33/F	Schizophrenia	No	Yes	3	Yes	Face, arms, legs
3	26/M	Schizophrenia	No	Yes	8	No	Arms, nails
4	34/F	Major depressive disorder	No	Yes	<1	Yes	Face
5	27/M	Substance use disorder	Yes (synthetic cannabinoid)	No	6	No	Nails, trunk
6	34/M	Alcohol use disorder	No	Yes	5	Yes	Scalp, arms
7	45/M	Bipolar disorder	No	Yes	5	No	Arms, legs
8	27/F	Bipolar disorder	No	Yes	<1	No	Face, scalp
9	51/M	Schizoaffective disorder	No	Yes	3	No	Trunk, legs
10	41/M	Substance use disorder	Yes (methamphetamine)	No	1.5	No	Arms, legs, trunk
11	41/F	Bipolar disorder	No	Yes	6	No	Face, arms, trunk
12	34/M	Substance use disorder	Yes (multiple)	No	2	Yes	Arms, nails
13	43/M	Schizophrenia	Yes (cannabinoid)	No	4	No	Arms, trunk

M: Male; F: Female; SPD: Skin-picking disorder; Substance use: Active psychoactive substance use during the index admission.

Anatomical involvement in our cases predominantly affected the extremities and trunk, with less frequent head (face/scalp) involvement. This pattern is broadly consistent with clinical cohorts in which the upper limbs are the most common sites, followed by the trunk and lower limbs, with head involvement reported less frequently (7).

Active psychoactive substance use was present in 4 of 13 SPD cases. Although prior epidemiologic research has reported associations between SPD and substance-related conditions, we did not observe a significant difference in active substance use between inpatients with and without SPD in our sample (30.8% vs. 29.6%, $p=0.922$). This null finding may partly reflect our diagnostic approach: skin picking judged to occur primarily in the context of acute substance effects or withdrawal was not classified as SPD according to DSM-5-TR criteria. The relatively high rate of active substance use among SPD cases in our series likely reflects the characteristics of an inpatient psychiatric population rather than a specific association within our cohort (8).

In our sample, a history of suicide attempt was identified in 8 of 13 patients with SPD (61.5%) and was significantly more frequent than in patients without SPD (32.2%, $p=0.031$). While the overall rate of suicide attempts in our cohort likely reflects the severity and complexity of psychiatric morbidity in an inpatient setting, the significantly higher proportion among SPD

cases underscores the importance of systematically assessing suicidality in SPD. The literature on the association between SPD and suicidal behavior remains mixed: one acute psychiatric sample study found no significant association after controlling for age and sex (5), whereas a study from Türkiye reported a higher rate of suicide attempts in individuals with SPD compared with healthy controls (15.0% vs. 1.9%) (9). Taken together, our findings highlight the need for further research to clarify whether the observed association reflects shared vulnerability factors (e.g., elevated impulsivity) or serves as a marker of greater severity of the primary psychiatric disorder.

The fact that only two of the thirteen SPD cases had been previously diagnosed suggests potential underrecognition of SPD in inpatient settings, as symptoms may be overlooked unless specifically assessed and patients may not spontaneously report them. This underscores the need to improve clinician awareness and to incorporate brief, structured screening questions into routine assessments. Only 4 of 13 patients reported a prior self-referred dermatology visit, which may reflect limited help-seeking, barriers to accessing dermatologic care, or low awareness that the condition is treatable. Limitations include the single-center design, the modest number of cases, and the lack of longitudinal follow-up, which may limit generalizability.

These findings highlight that SPD may be missed in psychiatric inpatient settings unless systematically assessed. Brief, structured inquiry about repetitive picking behaviors during admission, coupled with basic dermatologic examination, may facilitate earlier recognition and timely intervention, consistent with the broader psychodermatology framework that underscores the close skin–brain relationship, including their shared embryologic origin from the ectoderm. Increasing psychiatrists' awareness of dermatologic conditions such as SPD may improve detection and enable appropriate, timely management, and specialized collaborative models (e.g., psychodermatology clinics) may be particularly valuable for the integrated care of these patients.

Ethical Approval: The study was approved by Bakırköy Dr.Sadi Konuk Training and Research Hospital Clinical Research Ethics Committee (decision number: 2024-08-04; date: 19.08.2024).

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