

Dermotics. Classification and treatment of ten cases.

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Summary

Dermotics are defined as those repeated, compulsive movements, not always accessible by consciousness, causing several types of cutaneous damage. On the base of 10 particularly reported clinical cases, we discussed, from a psychosocial point of view, the importance of this so little explored reality. We subdivided the clinical cases into five psychodiagnostic categories, a useful operation that can make the clinical comprehension of such behaviours easier and can estimate the usefulness of a cooperation between pediatrician, dermatologist and psychologist.

Key words

Tic, dermatitis artefacta, dermatotics.

Tics are defined in psychology as repeated, compulsive, involuntary movements, actually not necessary, more or less puzzling, not always accessible to consciousness. They are felt by the subject as something irresistible, that he/she would want to avoid and sometimes is ashamed of it (2, 3).

Tics can manifest themselves in all areas of the body innervated by the somatic nervous system. Therefore, there are tics of the face, tongue, pharynx, head, neck, arms and hands. Tics can regard walking, breathing, speaking, the manipulation of dresses or objects, etc. (11).

These compulsive behaviours are more frequently observed in males. They start in subjects aged 5-9 years, reach a peak between 9 and 11 years, then stabilize till slowly decreasing during adolescence. Tic frequency in developmental age is estimated to be around 20%.

In these children an association between wounding behaviours and a wide range of psychological disorders is frequently observed. There can be problems referred to an emotional state, sleep and education or more specific disorders such as attention hyperactivity disorder and obsessive compulsive disorder (10).

The tic takes place and varies in intensity according to emotional, physical and environmental conditions. For example, the frequency of the tics increases when the child is tired, anxious or tensed or when he becomes conscious of the tic. On the other hand, there is a decrease in intensity, till complete resolution, in moments of relax and/or when the subject is engaged in activities that are particularly pleasant and soothing for him/her.

What causes a tic behaviour should be usually traced back to psychosocial factors. Among



Fig. 1: Petechiae on the chin (case n. 1) following the suction of the air of a glass put around the mouth.



Fig. 2: Hyperkeratosis due to chewing of the knuckles of the hands (case n. 3).

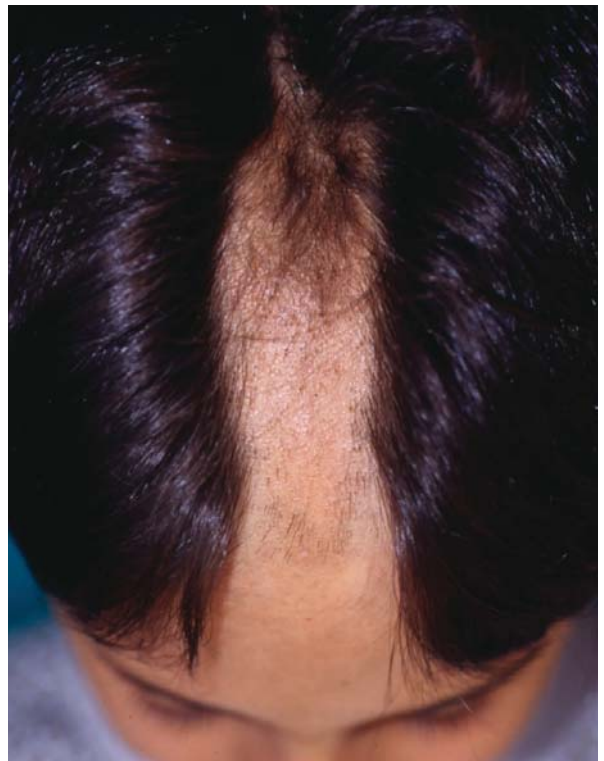


Fig. 3: Trichotillomania of the frontal and parietal region (case n. 4).



Fig. 4: Petechiae of the lobe of the ear (box) due to compulsive movements of rubbing (case n. 5).



Fig. 5: Irritative lesions of the right nipple due to compulsive pinching (case n. 6).

them it is particularly meaningful a lack of gratification for affection needs and demands that, in case of children, is related to family dynamics or to a specific educational environment (4).

When the tic provokes a damage on the skin (excoriation, hematoma, petechiae, etc.) we speak about “dermotics” (5). These tics are not uncommon to be found in the daily practice of the dermatologist or the pediatrician, although they are very rarely deeply investigated.

Only exceptionally dermatological tics are so severe to dominate the clinical frame within a defined syndrome -Gilles de la Tourette Syndrome- or to complicate it in some way -Prader Willi syndrome- (9).

Most cases of these tics do not need a specific treatment and only an explanation of the onset and recurrent self-wounding mechanism is enough for the parents, in order to help them and to relieve their anxiety and concern.

In order to deepen the significance of this particular type of self-harming behaviour, we took into consideration some cases that are particularly meaningful, selecting them among the clinical cases of the Department (VII) of Pediatric Dermatology of IDI-Rome (Italy), and those from the S.I.Der.P. (Italian Society for Pediatric Dermatology) Forum.

Clinical cases

Case 1. K., 8 yr. old, male. This patient enters the outpatient clinic with petechiae on the chin (Fig. 1) and no other disorder manifested. At a deeper examination the petechiae appear to be induced by the “glass game” played by K. during school time. Placing a glass around his mouth and chin he inspires the air creating vacuum, with the resulting negative pressure causing petechiae.

Case 2. G., 7 yr. old, male. Beside manifesting onychophagia this child repeatedly licks the lower lip and there is nothing that can stop him from doing so. In the summer and in the winter this is his smile.

Case 3. M., 14 yr. old, male. This patient, also affected by onychophagia, shows progressively increasing lesions on his hands. When asked

about his hands, he reveals that he “chews” them and claims “it itches”, “I got used to it”. The dermatological diagnosis is “chewing pads” (Fig. 2).

Case 4. M., 8 yr. old, male. This patient is the only child of a foreign couple recently migrated in Italy. His parents strongly stimulate him on searching the best way, toward perfection, to integrate himself within the cultural context of his new country. M. puts excessive effort into school and in his new social life. The parents force him to please his new Italian friends and never “answer back” when badly treated. This restraining feeling is responsible for a constant tension that he relieves by pulling his hair. He is affected by trichotillomania (Fig. 3).

Case 5. T., 2 yr. old, male. At first T. undertakes an examination in an outpatients' clinic for health disorders that are not related to dermatology. At the moment of an otoscopy, the physician observes an erythematous area on the lobe of his right ear. A deeper examination of this area reveals also the presence of small petechiae. The child, when relaxing or when “life is hard”, rubs and pinches the lobe of his ear and, not satisfied, he turns the same attention to the ear of his mother (Fig. 4).

Case 6. A., 5 yr. old, female. This little patient pinches her right nipple as a habit that helps her to relax and to go to sleep. During summertime, when she is light dressed, her habit deteriorates leading to excoriation (Fig. 5). Her parents, to stop such a practice and to confine her bruise, place a band-aid on her nipple, but the girl is stubborn and can hardly stop doing her habit.

Case 7. P., 3 yr. old, male. This patient displays lesions localized on the dorsal aspect of his nose, going up to the hair line. This is caused by a rubbing movement made with the edge of the pacifier, resulting in both a lichenified dermatitis and a traumatic alopecia (Fig. 6).

Case 8. L., 3 yr. old, female. During medical examination a small excoriated erythematous patch is found on the left cheek (Fig. 7). The mother reports that her daughter has the habit to suck 3rd and 4th finger of her hand and, at the same time, she methodically scratches her cheek with her index finger.

Case 9. A., 11 yr. old, female. Heavily under pressure in school, during the history class test, A. bites the mucous membrane of the lower lip. The salt on the fried potatoes irritates and worsens her lesions. Other lesions are not present in her mouth.

Case 10. F., 17 yr. old, male. From infancy this patient has the habit to frequently suck his thumbs and moreover, since he was 2 years old, he folds up his auricle, wedging it in the concha (Fig. 8). Such a habit induced luxation of the anthelix cartilage and consequent bilateral condritis.

Discussion

To properly operate, after a dermatological diagnosis of tic is made, we deemed relevant that an effort should be done in understanding what “upholds” the disorder and what maintains this specific behavior. Consequently we subdivided and classified the described clinical cases, not on dermatological criteria (concerning and focusing on the type of lesion provoked by the repetitive gesture of the child), but from a psychosocial point of view that could, at least with a certain proximity, make us hypothesize “why” the child enacts such a behavior.

According to the different psychosocial characteristics concurrent to compulsive behaviours, we defined the following classification of 5 different groups:

- a. play, as in cases 5, 6, 7 and 8;
- b. recurrent behaviour with no specific aim, as in cases 2 and 3 (1, 7);
- c. behaviours conditioned from an unsuitable environmental or educational constraint, as in case 4;
- d. behaviours linked to the need of the child to self-stimulate him self for pleasure or reassurance, as in cases 5, 6, 7 and 8;
- e. activities that are related to the need of relaxation and/or anxiety discharge, as in cases 9 and 10.

A dermotic response can be related to more than one of these five groups. As a matter of fact, for example, an unsuitable environmental or educational constraint can be associated with

the need to find relaxation and/or discharge mounting anxiety.

It may also happen that a change occurs in what initially determined a specific compulsive behaviour, so that there may be a shift from one group to another. For example, the need of the subject to self-stimulate him/herself for pleasure or reassurance, which is characteristic of the first years of infancy, can loose, along the development, its peculiar significance and thus become a recurrent behaviour with no specific aim (8).

This classification in different diagnostic subgroups appear to be useful to the physician, dermatologist or pediatrician, for a first diagnostic screening, made on the basis of the patient’s medical history. This can enable a preliminary evaluation of behavioral determinants that can suggest whether or not it is beneficial to ask for a psychological consultation.

The psychologist can turn out very useful for a deeper understanding of the patient’s conditions, with the subsequent goal of defining what kind of psychological practice should integrate the dermatological therapy.

According to the clinical frame of each single case, the psychologist’s work can be directly aimed at the child or be a counselling work with the parents.

In the latest case it is important to make them aware that, for example, when the behaviour that needs to be extinguished is a playing activity producing self harm, they can forbid it explaining him/her why it should be avoided. On the other hand, when it is a habit with no specific aim, trying to forbid it (verbally or physically) would not only be useless but also have a psychologically harmful effect on the child. In this case it is much more productive to ignore the bad habit and to put the child in the condition of being busy with different activities, mainly those ones that are more interesting and desirable for him, so to promote a “deliberate” drop of the deleterious habit.

Even though it is possible to intentionally control the tic for a short period of time (especially when the child becomes aware and self motivated to avoid it), it usually happens that the more the child is conscious, denies and puts

effort to overcome his tics, the more they become compulsory (12).

Therapy can be identified within four main approaches. All treatments have the specific goal to control and/or to extinguish tics when it is necessary to do so.

The pharmacological approach is carried out essentially through a sedative action, that is useful, for example, in case of tension or anxiety given by specific and temporary circumstances, such as a school test or a medical operation, so that a particular behaviour does not become a usual pattern.

A second therapeutic approach is psychomotor rehabilitation. Regulating and teaching a proper muscular motion, this technique endows the child with the ability to relax and voluntarily manage his/her body movements. It can turn out particularly useful, for example, in case of children who tend to be very tensed or children who

habitually display behaviors linked with no specific aim.

Another approach is psychotherapy of different kind. The latter is commonly administered in case the need of the child to relax and/or discharge anxiety, is related to specific and structured characteristics of personality.

In the environmental manipulation approach an “indirect” engage of the practitioner is preferred, avoiding to operate directly on the child, so that he would not feel “troubled” and different from other children, something that would paradoxically emphasize his/her problems. Through psycho-educational counselling for parents, the practitioner can, for example, focus his work on parental demands and/or the usual relational parent/child pattern of interaction, on family habits that can favour the tic phenomenon, on game activities that can be hurtful, so to avoid them, etc..



Fig. 6: Irritative lesions of the nose and traumatic alopecia due to rubbing of the pacifier (Case n. 7).

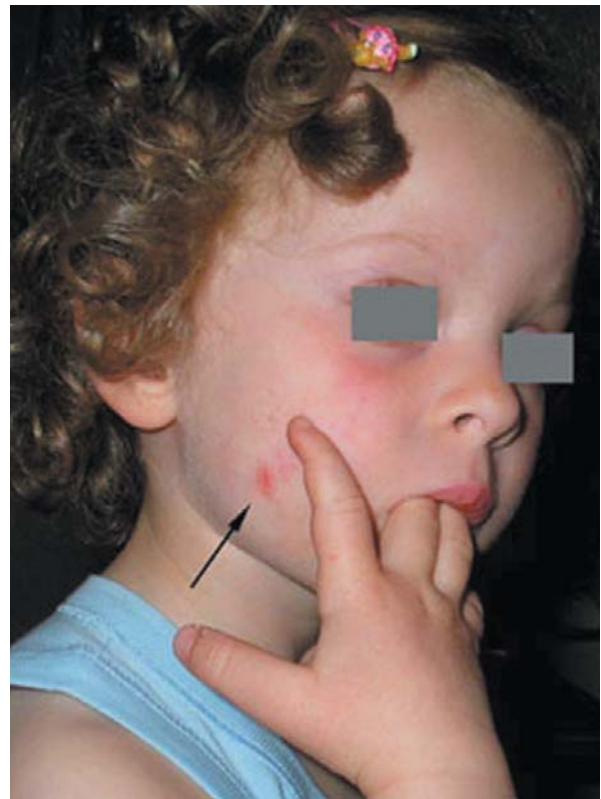


Fig. 7: Irritative lesions of the right cheek due to rubbing with the second finger (case n. 8).

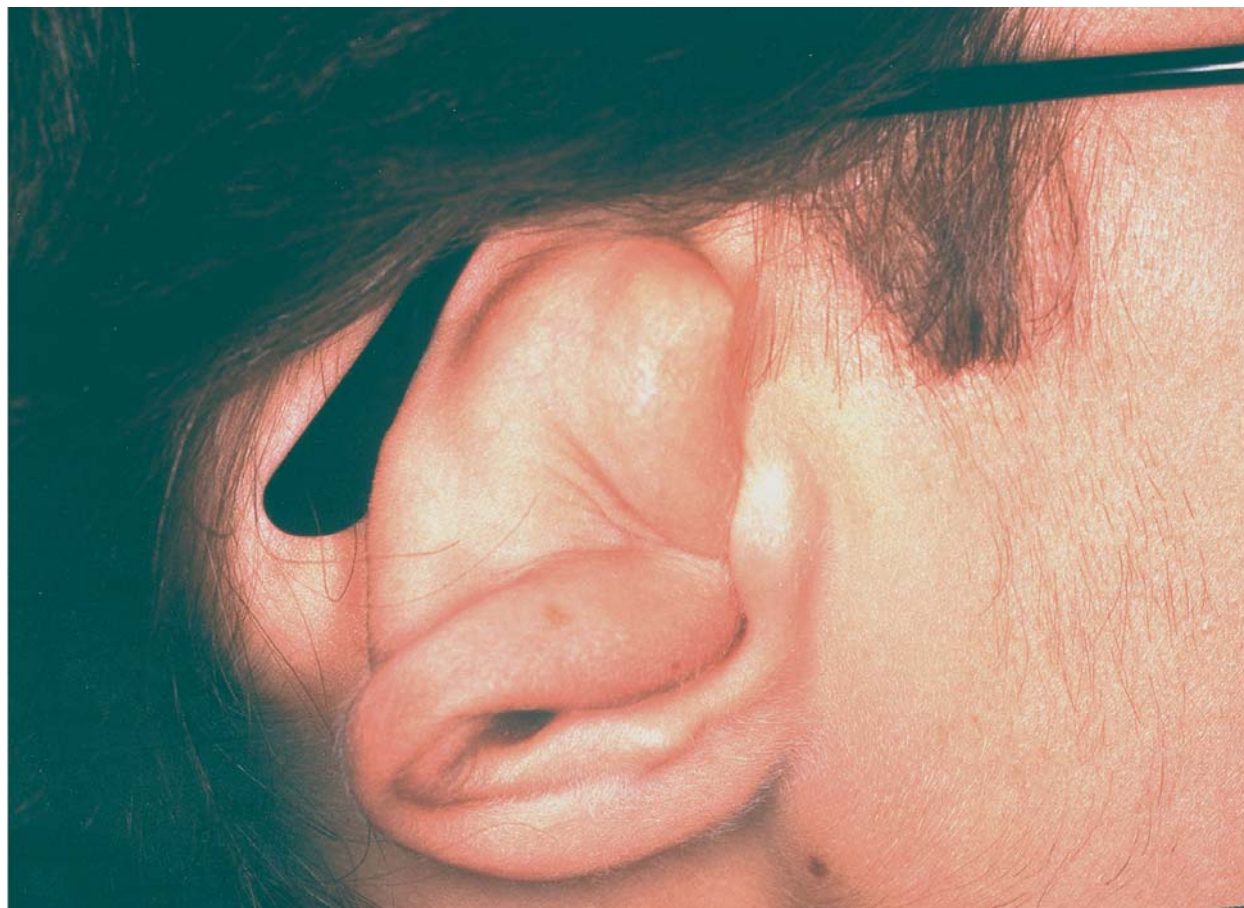


Fig. 8: This boy (case n. 10) folds up his auricle, wedging it in the concha till to cause luxation of the anthelix cartilage and condritis.

Conclusion

It is important not to point out the behavioural problem with the children, giving them the sense that they have something wrong defined as tic, but to analyse the possible reasons why the children are acting on themselves the way they do. When conditions make it appropriate to do so, it is best to “step into” the problem with an environmental manipulation.

Negative consequences that such repetitive behaviors may have for physical health, the subjects (mainly for what concerns self-image and self-evaluation of the child), the relational and social image and evaluation, have to be valued with great attention. Tics that spring in infancy or during adolescence, in the majority of the cases (more than 50%) “spontaneously”

resolve with development and/or when the psychological contingencies that encouraged them are not present or significant anymore.

What said takes us once again to the importance of mutual work as a turnout of a tight collaboration between the dermatologist, the pediatrician, the psychologist and the parents.

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