CASE REPORT

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Augmentation of sertraline with aripiprazole in a case of treatment-resistant skin-picking disorder

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ABSTRACT

Skin picking disorder (SPD) is a chronic psychiatric condition characterized by recurrent self-excoriation behaviors that often lead to marked psychosocial and functional impairment. Although the disorder is relatively prevalent and substantially disabling, therapeutic options for persistent and treatment-resistant cases remain scarce. The present case report discusses a 54-year-old woman with a three-decade history of SPD and coexisting depressive disorder who exhibited significant clinical improvement following combined treatment with sertraline and aripiprazole. This case underscores the potential clinical value of integrating selective serotonin reuptake inhibitors with atypical antipsychotics in addressing refractory forms of SPD.

Introduction

Skin picking disorder (SPD), which is among the obsessive-compulsive and related disorders in the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5), is characterized by repetitive skin picking behavior and causes serious functional impairments (1). The prevalence of SPD varies between 1.4% and 5.4% (2). The disorder typically begins in adolescence and can persist throughout life. Studies have shown that SPD behaviors often involve multiple body parts (3). Skin picking triggers vary widely between individuals. Psychosocial factors such as stress, anxiety, boredom, fatigue, and anger often initiate the behavior, and the resulting scars worsen anxiety, contributing to a vicious cycle that negatively impacts social and occupational functioning (4).

Neuroimaging and neurobiological evidence point toward dysfunctions in cortico-striatal and limbic circuitry, implicating regions responsible for mood modulation, inhibitory control, and habit learning. Abnormalities in white matter connectivity and altered dopaminergic reward responses have been proposed as contributory mechanisms (5).

The course of SPD is usually chronic, and treatment-resistant cases are common. Early diagnosis and treatment are

critical to prevent functional impairments associated with SPD (6). However, Grant and Chamberlain reported that 87.1% of individuals diagnosed with SPD never receive treatment (7). There is currently no accepted first-line pharmacotherapy for SPD. Similarly, no randomized controlled trials are investigating the effectiveness of augmentation strategies in treatment-resistant cases. Nonetheless, several case reports have indicated that combining selective serotonin reuptake inhibitors (SSRIs) with atypical antipsychotics such as aripiprazole, olanzapine, or paliperidone may lead to a marked reduction in skin-picking symptoms (8). This case report presents the significant clinical improvement of a female patient who had been followed for more than 30 years with a diagnosis of SPD and who had previously failed numerous pharmacological interventions.

Case Presentation

A 54-year-old, married, female patient presented with depressive symptoms including pessimism, lack of motivation, fatigue, and loss of interest and pleasure. The patient provided written consent for the publication of this case.

Over the past three decades, the patient experienced several recurrent episodes of depression and had undergone multiple pharmacological treatments, including clomipramine, citalopram, paroxetine, and risperidone. However, she had remained without psychiatric medication for approximately three years before presentation. Based on DSM-5 diagnostic criteria, she met the conditions for both depressive disorder and SPD (1). She exhibited obsessive-compulsive personality traits, including marked perfectionism, meticulousness, and strict adherence to rules. No criteria were met for a specific diagnosis of obsessive-compulsive disorder (Figure 1).

At the time of the interview, the patient reported no complaints of skin picking behavior. However, physical examination revealed skin-picking on multiple sites on her arms, legs, and abdomen. A detailed interview indicated that these lesions had been present for approximately 30 years, with their severity fluctuating over time but never fully resolving. She stated that she engaged in skin-picking behavior involuntarily, particularly during stressful and challenging situations. When asked about the behavior, she responded, “I don’t even realize I’m doing it until someone points it out”.

The patient denied any history of substance use. There was likewise no familial predisposition to dermatological conditions, and dermatologic evaluation revealed no primary dermatosis that could account for the observed lesions. Neurological assessment and standard laboratory investigations yielded results within normal ranges.

Treatment process

Sertraline therapy was initiated at a daily dose of 50 mg and gradually increased to 100 mg/day. After eight weeks of follow-up, a marked amelioration in depressive symptomatology was noted. However, no improvement was noted in skin-picking behavior, and new lesions had developed. Following a comprehensive evaluation, the same dose of sertraline was continued, and off-label augmentation with aripiprazole at a dose of 5 mg/day was initiated. The rationale for the combination therapy was explained to the patient, and written informed consent was obtained. After the addition of aripiprazole, a noticeable reduction in skin-picking behavior was observed starting from the fourth week. By the twelfth week, the patient’s score on the skin-picking-adapted version of the Yale-Brown Obsessive Compulsive Scale modified for Neurotic Excoriation (NE-YBOCS) (9) had decreased from 24 to 9, corresponding to an approximate clinical improvement of 62.5%.

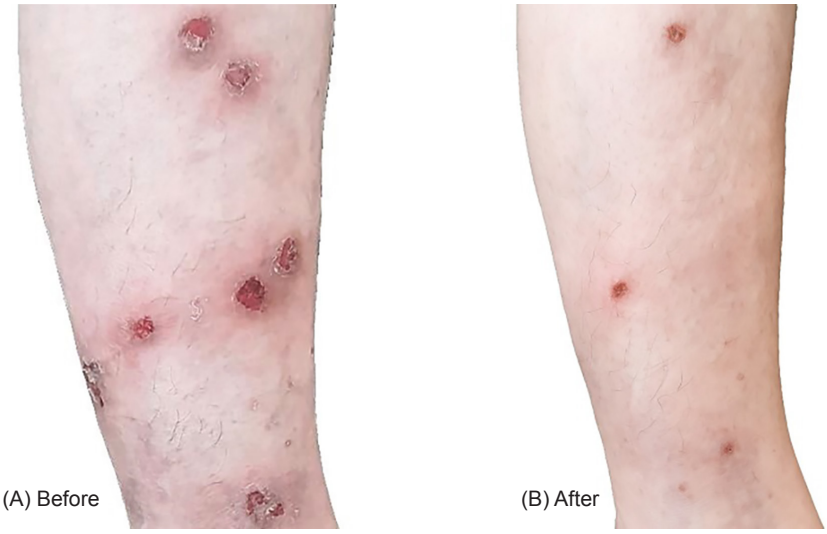

Figure 1. (A.B) The lesions on the arms, abdominal area, and legs caused by skin picking significantly improved with the sertraline + aripiprazole combination (appearance of the lesions on the patient's right leg before and after treatment)

Discussion

This case is noteworthy in demonstrating that significant clinical improvement can be achieved in the course of chronic and treatment-resistant SPD through an appropriate pharmacological strategy.

The neurobiological basis of SPD involves dysfunctions in the serotonergic and dopaminergic systems (10,11). Within this framework, SSRIs are considered the primary pharmacologic option. Evidence from a double-blind, placebo-controlled clinical trial evaluating fluoxetine in patients with neurotic excoriation demonstrated its therapeutic efficacy. Similarly, sertraline and escitalopram have also been shown to be effective in the management of SPD (2).

However, in cases where SSRI monotherapy fails to produce an adequate clinical response, the addition of atypical antipsychotics is considered a viable augmentation strategy (12,13). Moreover, several case reports have suggested that dopaminergic reward pathways may serve as important pharmacological targets in SPD, thereby making antipsychotics a particularly suitable class of agents (14,15). Aripiprazole functions as a partial agonist at 5-hydroxytryptamine (5-HT)1A receptors, an antagonist at 5-HT2A receptors, and a partial agonist at dopamine D2 receptors. Through its modulatory action on D2 receptors, it exerts therapeutic benefits, particularly in disorders characterized by impaired impulse control. Consistent with this pharmacodynamic profile, a previous case of treatment-resistant SPD reported that adjunctive aripiprazole with venlafaxine-a serotonin-norepinephrine reuptake inhibitor used for anxiety and depressive disorders-resulted in complete remission of the picking behavior (15).

This case highlights that the combination of sertraline and aripiprazole may be an effective pharmacological treatment option, particularly in chronic and treatment-resistant cases of SPD. However, this case report is uncontrolled in nature and the observed improvement may partly reflect a placebo effect. Additionally, while the NE-YBOCS provides a structured measure for skin picking symptoms, depressive symptoms were not assessed with a structured-standardized scale. Future case reports and clinical studies should integrate such validated tools to strengthen clinical rigor.

Ethics

Informed Consent: The patient provided written consent for the publication of this case.

Footnotes

Financial Disclosure: The author declared that this study received no financial support.

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