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Dermatological Manifestations of Psychiatric Disorders: Narrative Review

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ABSTRACT

Background: Psychodermatology is an interdisciplinary field that examines the complex interplay between psychological factors and dermatological symptoms. While emotional stress is known to influence many skin diseases, there remains limited awareness of psychiatric disorders that primarily manifest through self-inflicted skin lesions. Aim: The purpose of this narrative review is to present current knowledge on selected psychiatric conditions with primary dermatological manifestations, with an emphasis on clinical features, diagnostic challenges, and therapeutic approaches. Material and methods: Authors conducted literature review using PubMed and Google Scholar databases, focusing on publications relevant to the topic of publication. After exclusion, 61 records were identified as meeting predefined criteria. Results: The reviewed conditions show diverse clinical presentations, often mimicking primary dermatological diseases, which complicates diagnosis. All four disorders share common features, such as impaired impulse control, psychiatric comorbidities (e.g., depression, anxiety, and obsessive-compulsive disorder), and a chronic, relapsing course. Neurobiological and psychological mechanisms are multifactorial and not yet fully understood. Effective treatment requires an interdisciplinary approach combining pharmacotherapy (e.g., SSRIs, antipsychotics) and psychotherapy, particularly cognitive-behavioral therapy. Early diagnosis and collaboration between dermatologists and psychiatrists significantly improve outcomes. Conclusions: Psychiatric disorders that appear as skin conditions are still difficult for doctors to diagnose. To improve management of psychodermatoses, more focus should be put on creating interdisciplinary teams, setting clear diagnostic criteria and bringing more awareness of the topic among physicians. More research should focus on clarifying what causes development of psychodermatological disorders and setting up effective treatment guidelines.

Keywords: psychodermatology, trichotillomania, dermatillomania, hair-pulling disorder, skin-picking disorder, dermatitis artefacta, delusional parasitosis

1. INTRODUCTION

Psychodermatology is a field that continues to grow, and it studies the relationship between skin disorders and mental health. The interplay between the mind and the

skin was first recognized in ancient times. However, the last 25 years have marked significant progress in this area (Jafferany & Franca, 2016). It is well established that stress, anxiety, and depression can affect skin health. These issues can lead to conditions like psoriasis or eczema (Rodriguez-Vallecillo & Woodbury-Fariña, 2014). Yet, less focus has been given to primary psychiatric disorders that manifest with skin symptoms or behaviours. This subgroup includes, among others, trichotillomania, excoriation disorder, delusional parasitosis, and dermatitis artefacta (Jafferany, 2007). For example, delusional parasitosis, although rare, presents with intense somatic delusions and can be triggered or exacerbated by factors such as infections, including COVID-19 (Carlini et al., 2022). Excoriation disorder and trichotillomania are now recognized as part of the obsessive-compulsive spectrum in the DSM-5, requiring distinct therapeutic approaches (Krzyszkowiak et al., 2019).

In recent years, awareness of psychodermatoses has increased. This led to a growing amount of literature addressing their classification and management (Ferreira & Jafferany, 2021; Ferreira et al., 2024). Nevertheless, many publications frequently place them together in the category of psychodermatology without providing a comprehensive exploration of their neurobiological mechanisms, genetic background, differential diagnoses, or up-to-date treatment strategies.

To understand psychodermatology, it is necessary to recognize the complex interplay between psychological and dermatological factors. Several classification systems for those conditions have been proposed. One of the most popular, cited in available literature is the model introduced by Koo and Lee (2003). This classification identifies four main groups. The first includes psychophysiological disorders, primarily dermatological conditions such as acne, atopic dermatitis, or psoriasis. These disorders are activated or exacerbated by psychological conditions of the patient, for example, stress or anxiety. The second group comprises psychiatric disorders with dermatological symptoms, such as trichotillomania, excoriation disorder, delusional parasitosis, and dermatitis artefacta. In these cases, the disorder originates from psychiatric pathology, but it is visible to a different degree on the skin of patients. The third category consists of dermatological diseases that may lead to psychiatric symptoms due to their psychosocial impact, including disorders such as vitiligo or alopecia areata (Koo & Lee, 2003). Publications distinguish a fourth group, miscellaneous disorders, which includes conditions that do not fit into the previous categories but are nonetheless considered part of psychodermatology (Jafferany, 2007; Jafferany & Franca, 2016). This paper focuses on the second group of diseases, psychiatric disorders with dermatological manifestations, highlighting their clinical complexity, diagnostic challenges, and treatment approaches.

Research Objective

To conduct a narrative review of selected psychiatric disorders primarily manifesting through dermatological symptoms, with emphasis on their classification, psychological and neurobiological underpinnings, clinical features, diagnostic complexity, and treatment approaches.

Research Problems

How are conditions such as trichotillomania, skin-picking disorder, delusional parasitosis, and dermatitis artefacta currently classified in psychiatry and dermatology? What are the mechanisms for the development and persistence of these disorders? What specific challenges exist in the differential diagnosis of these disorders? How effective are current therapeutic interventions, and to what extent do they integrate psychiatric and dermatological care?.

Research Hypotheses

Psychodermatological conditions are underdiagnosed because of their atypical clinical presentation, which often mimics other diseases, and the low cooperation between dermatologists and psychiatrists.

2. REVIEW METHODS

2.1. Search strategy

The search included articles published in PubMed and Google Scholar, with a focus on studies published between January 2000 and June 2025, particularly emphasizing recent advances from the last five years.

The following keywords were used in various combinations:

"psychodermatology", "trichotillomania" OR "hair-pulling disorder", "skin-picking disorder" OR "excoriation disorder", "delusional parasitosis" OR "delusional infestation", "dermatitis artefacta" OR "factitious skin disorder", "obsessive-compulsive spectrum disorders", "neurobiology" "genetics", "treatment", "etiology", "psychoterapy", "pharmacotherapy", "DSM-5" AND "classification"

Articles were included based on their relevance to the topic, publication in peer-reviewed journals, and availability in English or Polish. Both clinical studies and reviews were considered. The reference lists of selected articles were also reviewed to uncover additional relevant sources (Figure 1).

Exclusion criteria included non-peer-reviewed content that lacked clinical or conceptual relevance, as well as publications unrelated to psychodermatological conditions. Case reports were included only when they offered unique insight or were supported by broader theoretical or clinical discussion.

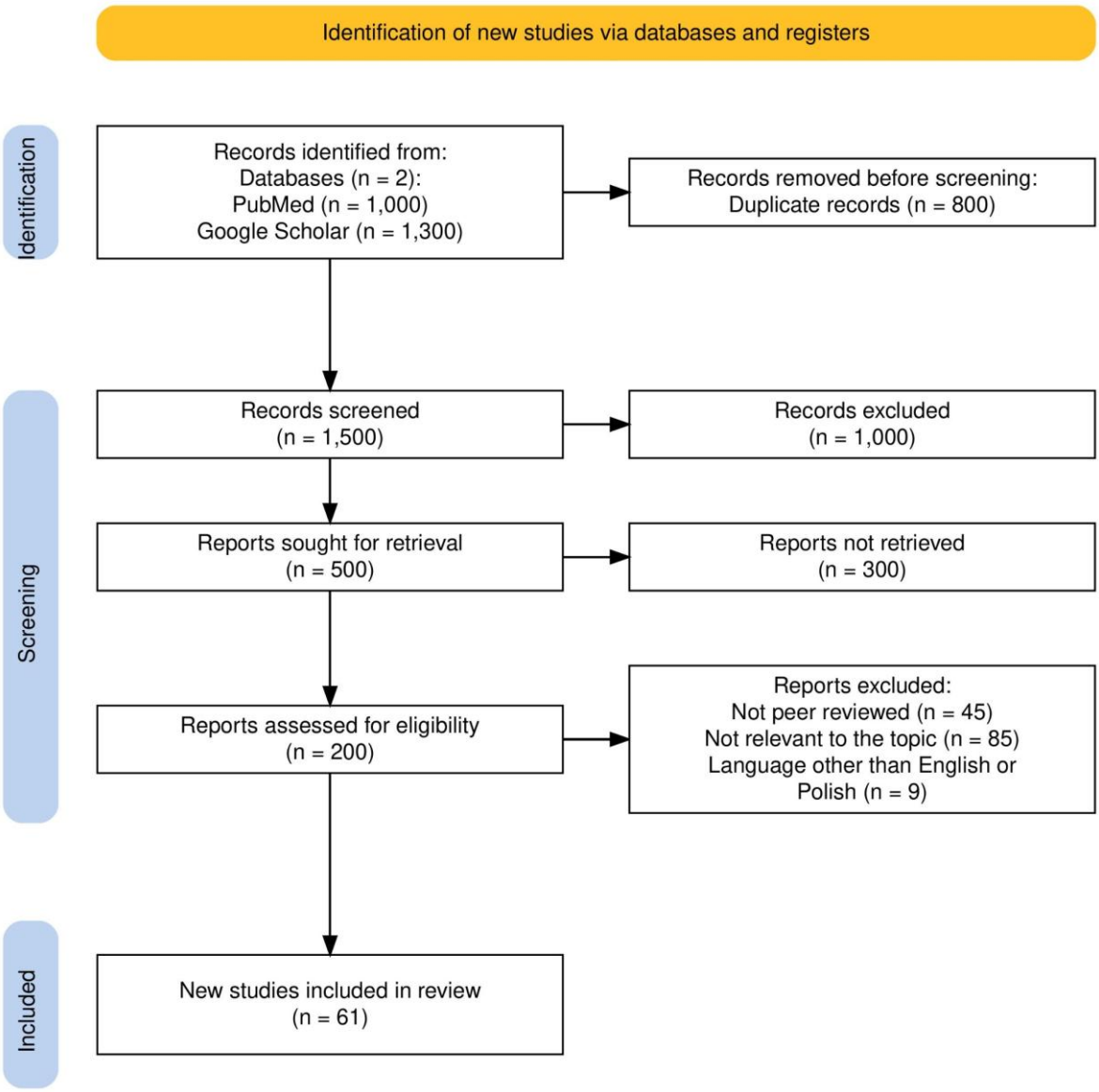

Figure 1. PRISMA flowchart for the article selection process.

3. RESULTS AND DISCUSSION

The four main disorders discussed in this review are summarised in Table 1. It includes their classification, clinical features, prevalence, comorbidities and most commonly chosen treatment options.

Table 1. Summary of key psychodermatological disorders discussed in this review

Disorder	DSM-5 Classification	Key Features	Estimated Prevalence	Common Comorbidities	Main Treatment Approaches
Trichotillomania	OCRDs	Repetitive hair-pulling behavior leading to visible hair loss and distress	~1–2%	Depression, anxiety, OCD	CBT (especially Habit Reversal Training), SSRIs, N-acetylcysteine (NAC), olanzapine
Skin-Picking Disorder	OCRDs	Compulsive picking of skin causing lesions and scarring; feelings of guilt	~1–5%	Anxiety, depression, body dysmorphic disorder, OCD	CBT (HRT, ERP), SSRIs, NAC
Delusional Parasitosis	Delusional Disorder, Somatic Type	Fixed false belief of parasitic infestation	Rare	Depression, schizophrenia, substance abuse, neurological disorders	Antipsychotic medications
Dermatitis Artefacta	Factitious Disorder (Self-Inflicted Lesions)	Intentional creation of skin lesions; patients usually deny self-infliction	Unknown (rare)	Borderline personality disorder, dissociative disorders	Integrated dermatological and psychiatric care

3.1. Trichotillomania

3.1.1. Definition and DSM-5 Classification

Trichotillomania (TTM), also known as hair-pulling disorder, is a condition that involves dermatology and psychiatry. The DSM-5 classifies it as an obsessive-compulsive or related disorder (OCRD), which is characterized by recurrent, uncontrollable urges to pull out hair from various regions of the body. This behaviour often leads to visible hair loss and psychological distress (Melo et al., 2022). Affected individuals often experience comorbid symptoms of depression, anxiety, and a general reduction in quality of life. Although trichotillomania has been described in the literature for decades, it was not formally classified until 1987, in the DSM-III-R (Grant & Chamberlain, 2016). Since DSM-5, it has been grouped with other obsessive-compulsive related disorders, including excoriation (skin-picking) disorder, body dysmorphic disorder, and hoarding disorder.

3.1.2. Epidemiology and Onset

The estimated lifetime prevalence of trichotillomania in the general population is 1% to 2%, with adolescents and young adults having higher rates (Grant & Chamberlain, 2016). TTM is affecting women more often, with a female-to-male ratio estimated at around 4:1 (Melo et al., 2022). However, the gender distribution in children seems to be equal (Grant & Chamberlain, 2016).

3.1.3. Clinical Features and Diagnostic Criteria

Patients with this disorder report many failed attempts to cut down or stop this practice. The condition must cause significant distress or impairment in one or more of the following domains of functioning: social, occupational, or other important areas, and it cannot be better explained by another medical or psychiatric disorder (Ferreira & Jafferany, 2021). Hair pulling can involve any region of the body, with the scalp, eyebrows, and eyelashes being the most commonly affected sites. The behavior may occur consciously (focused pulling) or unconsciously (automated pulling), and is frequently accompanied by inspecting, manipulating, or even ingesting the hair (Melo et al., 2022). In cases where the pulled hair is ingested—a behavior known as trichophagia—patients are at risk of developing the so-called Rapunzel syndrome, a rare but serious condition characterized by the formation of a trichobezoar, or hairball, that extends from the stomach into the duodenum (Kim et al., 2025). Patients often suffer from emotional distress that accompanies TTM. It should be treated seriously, for it can result in suicidal tendencies or behaviors in extreme instances (Grant et al., 2023).

3.1.4. Psychological and Neurobiological Mechanisms

The etiology of trichotillomania is complex. Genetic, neurobiological, and psychological factors are involved in its development. Twin studies have demonstrated moderate heritability of the disorder (Monzani et al., 2014; Novak et al., 2009). Building on evidence of genetic involvement in obsessive-compulsive disorder (OCD), a recent systematic review highlighted the need for genome-wide studies in trichotillomania (Reid et al., 2024). In response, a genome-wide association study conducted by Halvorsen et al. analysed genotype data from TTM cases and unaffected controls. Although no single genetic variant achieved genome-wide significance, individuals with TTM were found to carry a higher polygenic risk load for psychiatric disorders such as depression and OCD. These results strengthen the role of genetic predisposition in TTM and indicate the necessity for larger studies to delineate specific risk genes (Halvorsen et al., 2025).

Research based on neuroimaging and neurocognitive investigations also points to dysregulation in somatosensory, sensorimotor, and fronto-striatal brain circuits. Those patterns are similar to those observed in other obsessive-compulsive spectrum disorders (Roos et al., 2023; Reess et al., 2016). Stress and emotional disregulation seem to have a big impact on the development of TTM. Hair-pulling frequently serves as a coping response to internal tension (França et al., 2019).

3.1.5. Treatment Approaches

Both pharmacological, as well as psychotherapeutic interventions, are used to treat trichotillomania (Christensen et al., 2023; Nina Domínguez et al., 2025). The most evidence-based psychotherapeutic approach is habit reversal training (HRT), a form of cognitive-behavioral therapy that helps patients increase awareness of pulling behavior and implement competing responses. Other therapies, including dialectical behavior therapy (DBT) and acceptance and commitment therapy (ACT), have also been found useful for helping individuals with TTM's emotion regulation deficits (Jafferany & Patel, 2018). On the pharmacologic front, the most researched medications include selective serotonin reuptake inhibitors (SSRIs), clomipramine, olanzapine, N-acetylcysteine (NAC), and dronabinol (Grant, 2019; Sani et al., 2019). Though each has been found to have therapeutic value in small sample studies, none has yet become a standard of care. NAC, specifically, has been found effective in the adult population (Goldin et al., 2025; Lee & Lipner, 2022). Available evidence suggests larger randomized controlled studies are needed to determine definitive pharmacological treatment guidelines for trichotillomania (Nina Domínguez et al., 2025).

3.2. Psychogenic Excoriation (Skin Picking Disorder/Excoriation Disorder)

3.2.1. Definition and Etiology

Excoriation disorder (ED) is a psychodermatosis that is also known as skin-picking disorder, neurotic excoriation, or dermatillomania. It is described by patients suffering from it as recurring and irresistible urge to pick at their own skin. This behaviour often results in visible wounds or scars and significant functional impairment (Eskeland et al., 2021; Torales et al., 2020). The disorder is classified within obsessive-compulsive and related disorders (OCRDs) in the DSM-5. Although the condition is not very rare, as it is estimated to affect 1–5% of the general population, skin-picking disorder is often overlooked by physicians (Alfahaad et al., 2024). To diagnose ED, it is required that the behavior causes significant emotional distress or substantial impairment in at least one important area of life, such as academic, occupational, or social functioning (Eskeland et al., 2021). Skin lesions resulting from repetitive picking may lead to difficult-to-treat scarring and, in severe cases, to secondary infections. ED can have its onset at any age but is most commonly diagnosed in adolescence years. Dermatological conditions characterized by skin imperfections, such as acne or eczema, are common triggers for patients to start picking at their skin (Lochner et al., 2017).

3.2.2. Differential Diagnosis

One of the most characteristic features of dermatillomania is the presence of guilt, shame, or a sense of lost control following picking of one’s skin. Several conditions may present with similar symptoms and should be considered in the differential diagnosis. In delusional parasitosis, skin manipulation is driven by a fixed, false belief of infestation. In body dysmorphic disorder, the behavior can be in reaction to perceived appearance defects. In dermatitis artefacta, the damage is self-induced; however, the patient often denies it, and the motive is usually to attain attention or care (Eskeland et al., 2021; Torales et al., 2020).

3.2.3. Psychological and Neurobiological Mechanisms

The pathogenesis of skin-picking disorder is complex. It involves genetic, neurobiological, and psychological factors. The key factor in he development and perpetuation of ED is emotional dysregulation. ED sometimes co-occurs with psychiatric conditions such as anxiety disorders, depression, obsessive-compulsive disorder (OCD) and body dysmorphic disorder. This fact supports its classification among the OCRDs (Grant & Chamberlain, 2020). One particular voxel-based morphometry study of 220 people, included 123 patients with ED, who demonstrated decreased gray matter volume in brain areas related to emotional processing, interoception, and motor control in comparison to patients who didn't suffer from skin-picking disorder. These neuroanatomical findings partly overlap with those described in patients with OCD, though further research is needed to clarify this observation (Schienle & Wabnegger, 2024). Preliminary evidence also suggests glutamatergic dysfunction in ED, which has prompted the investigation of glutamate-modulating agents—most notably N-acetylcysteine (NAC)—as potential treatment options (Lochner et al., 2017; Sani et al., 2019). From a genetic standpoint, twin and family studies have indicated a potential hereditary component for all OCD related disorders (Browne et al., 2014).

3.2.4. Treatment

Cognitive-behavioral therapy (CBT) is usually the first line of treatment for skin-picking disorder. The most important techniques comprise habit reversal training, cognitive restructuring, and exposure and response prevention (Alfahaad et al., 2024; Sani et al., 2019). If the psychotherapy alone proves inadequate, pharmacotherapy may be added. Selective serotonin reuptake inhibitors (SSRIs) are considered as the most effective so far, when it comes to pharmacological options of treating ED (Lochner et al., 2017; Modanlo et al., 2025). N-acetylcysteine (NAC) has also shown promising results in clinical trials (Eskeland et al., 2021; Modanlo et al., 2025). Other medications that have been investigated include tricyclic antidepressants (TCAs) and naltrexone (Sani et al., 2019). Although not supported by strong clinical evidence, alternative treatments such as acupuncture and hypnosis have been proposed as adjunctive treatments to help reduce anxiety and stress related to the disorder (Alfahaad et al., 2024). One of the new ideas in recent publication is suggesting to use nanotechnology-based materials to create protective materials that could be placed on skin to protect patients physically from skin picking. This could prevent the development of new lesions, while also allowing the existing wound to heal properly (Ravipati et al., 2021).

3.3. Delusional Parasitosis

3.3.1. Clinical Characteristics and Management

Delusional parasitosis (DP), also referred to as delusional infestation or Ekbom's syndrome, is a relatively rare psychiatric condition characterized by a fixed, false belief of being infested with parasites—most commonly insects or worms—despite the complete absence of objective medical evidence. This state can present in two forms: primary and secondary delusional parasitosis (Freudenmann & Lepping, 2009; Mumcuoglu et al., 2018; Reich et al., 2019). In the primary form, symptoms arise spontaneously, without any underlying medical or psychiatric condition. In the secondary type, symptoms are a consequence of another disorder, most frequently substance use, medication withdrawal, or neurological illness (Brownstone et al., 2022). Patients with DP frequently first seek help from dermatologists rather than psychiatrists (Gajbhiye et al., 2023) as their symptoms often manifest as disturbing sensations such as tingling, itching, or a crawling feeling under the skin—sensations they attribute to parasitic infestation (Reich et al., 2019). Only later are they referred to psychiatric services, but due to the strength of their conviction, many continue consulting multiple specialists, often resisting psychiatric explanations (Mumcuoglu et al., 2018). This pattern can result in frustration, a sense of helplessness, and, in more severe cases, depressive symptoms (Freudenmann & Lepping, 2009). DP may be secondary to various psychiatric disorders such as schizophrenia, bipolar disorder, major depression, anxiety disorders, obsessive-compulsive disorder, and illness anxiety disorder. There are also reports of DP triggered by substance abuse (Knapp et al., 2019), neurological conditions (Ochiai et al., 2019), adverse drug reactions (Kemperman et al., 2022) and even infectious diseases (Ansari & Bragg, 2023).

3.3.2. Epidemiology and Clinical Presentation

DP remains a relatively uncommon diagnosis (Ansari & Bragg, 2023). Patients are often entirely convinced of their infestation and resistant to any contradictory evidence. In some cases, individuals express fear of spreading the infestation to family members (Mumcuoglu et al., 2018). Hallucinations can be tactile, visual, or auditory (Gajbhiye et al., 2023). In 5–15% of cases, close family members begin to share the same delusional belief—an occurrence referred to as shared psychotic disorder-delusional parasitosis with

folie à deux (Reich et al., 2019). One of the hallmark features of delusional parasitosis (DP) is a phenomenon known as the matchbox sign. Here, patients commonly bring in small containers—matchboxes, plastic bags, or jars—that hold material they believe is a parasite, but which more often represents skin debris, lint, or scabs. This phenomenon highlights the strength of the delusion and is often presented as "evidence" during consultations (Mumcuoglu et al., 2018).

3.3.3. Treatment

A main difficulty in treating patients suffering from delusional parasitosis is the patient's inability to understand the psychiatric nature of the disorder. Therefore, a baseline requirement for successful treatment is the cultivation of a patient-physician cooperation founded on competent communication, empathy, and the involvement of both parties in the therapeutic process. Additionally, an interdisciplinary approach is essential (Mumcuoglu et al., 2018). Other possible somatic causes of symptoms, especially parasitic infections, should be excluded before the start of psychiatric treatment (Coetzee et al., 2023). Antipsychotic medications are frequently used as the first line of treatment. Nevertheless, new reports point out the necessity for further research and creation of standardized treatment methods for all physicians (Assalman et al., 2019; Katamanin & Jafferany, 2024).

3.4. Dermatitis artefacta

3.4.1 Definition, Classification and Clinical Presentation

Dermatitis artefacta (DA), also known as factitious skin disorder, is a psychodermatological condition that lies at the interface of dermatology and psychiatry. DA is characterized by the intentional self-infliction of skin lesions, which is sometimes performed in a partially unconscious manner. Patients might do this as a form of emotional release, to gain attention, to communicate inner distress, or to indicate that they need help (Chandran & Kurien, 2022). Diagnosis can be tricky since patients usually deny inducing the lesions themselves. The skin changes can vary widely in appearance and are most often located on areas that are easily accessible with the dominant hand. Observed lesions may include excoriations, ulcers, blisters, burns, or abrasions of varying severity (Rodríguez Pichardo & García Bravo, 2013).

3.4.2. Differential Diagnosis

DA is difficult to diagnose because its clinical presentation may simulate a broad spectrum of different dermatologic disorders. Therefore, it should only be considered after ruling out other organic causes of skin lesions (Ciccarese et al., 2024). Although DA shares some features with skin picking disorder—namely, self-inflicted lesions—a key distinction is that patients with skin picking disorder often acknowledge their role in creating the wounds. At the same time, those with DA tend to deny it (Rodríguez Pichardo & García Bravo, 2013). In the case of crusted or blistering lesions, it is important to rule out infectious dermatoses like ecthyma or herpes simplex (Singh et al., 2023). Another factor that makes diagnosis challenging is the variety of techniques patients utilize to create lesions (Rodríguez Pichardo & García Bravo, 2013). One particularly striking case involved an 11-year-old girl who applied eosin to her skin to simulate erythema (Cerejeira et al., 2021). Attention to lesion morphology can be helpful; the shapes are often unusual or geometrically bizarre (Singh et al., 2023). In severe cases, patients can go so far as to falsify medical records to substantiate the conviction that they are suffering from an undiagnosed serious dermatologic illness (Basfar et al., 2023).

3.4.3. Psychological Mechanisms and Comorbidities

A psychiatric history may be valuable in identifying DA, as the disorder often coexists with various psychiatric conditions (Torales et al., 2023). High comorbidity has been noted with borderline personality disorder and dissociative disorders (Gattu et al., 2009). What differentiates DA from other types of factitious disorders, like Munchausen's syndrome, is the predominantly unconscious nature of the motivation for the behavior. Although both are self-inflicted, DA does not have the overt, conscious intent to deceive for secondary gain. Rather, it is a manifestation of internal psychic conflict through the skin (Wong et al., 2013).

3.4.4. Treatment

Due to the complexity of DA, optimal treatment should ideally occur in an integrated care setting that involves both psychiatry and dermatology (Torales et al., 2023; Mukundu et al., 2023). Treatment of the skin lesions may involve topical or systemic antibiotics if there is evidence of secondary infection. However, the essence of treatment should focus on the primary psychiatric disorder causing the self-induced dermatological symptoms (Chandran & Kurien, 2022).

3.5. Future Directions

The field of psychodermatology has certainly made great advancements in recent years. However, there is a necessity to establish standardized protocols for the treatment and management of disorders in this domain (Mostaghimi 2023; Mostaghimi & Noughani, 2022). There have been proposals to create official psychodermatology fellowships for psychiatrists and dermatologists, which could improve interdisciplinary expertise and cooperation (Ryan & Wagner, 2021). To create targeted treatments, further research on the exact genetic origin of OCD-related disorders is needed (Browne et al., 2014).

4. CONCLUSION

Diagnosing psychodermatological disorders is often a significant challenge for physicians because it requires extensive knowledge of psychiatry and dermatology. Although trichotillomania, skin-picking disorder, delusional parasitosis, and dermatitis artefacta differ in their specific features, they share many common elements—including overlapping symptoms, emotional dysregulation, and complex etiologies. Due to their intricate clinical presentations, these disorders are often difficult to diagnose and are consequently frequently mismanaged or inadequately treated. Coordinated care from psychiatrists, dermatologists, and psychotherapists, as well as the therapeutic alliance with the patient based on trust, respect, and empathy, is essential to high-quality care. Current treatment methods, primarily based on psychotherapy and pharmacotherapy, are effective in some cases. Further research into the genetic and neurobiological underpinnings of these disorders should open up the possibility of developing novel and more effective treatment approaches. The quality of care will benefit from several initiatives, including standardized diagnostic criteria, evidence-based treatment guidelines, appropriate training in psychodermatology for both psychiatrists and dermatologists, and the establishment of psychodermatology clinics or units.

Author's Contributions

Anita Szymańska: Conceptualisation, Formal analysis, Project administration, Writing - review and editing
Marta Dzieciątkowska: Software, Investigation
Weronika Pierudzka: Methodology, Check
Agnieszka Mariowska: Resources, Writing - rough preparation
Paulina Horwat: Data curation, Visualisation

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Informed consent

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Ethical approval

Not applicable.

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Conflict of interest

The authors declare that there is no conflict of interest.

Data and materials availability

All data associated with this work are present in the paper.

REFERENCES

1. Alfahaad H, Aldehri M, Alsaiari SA, Asiri F, Alfataih M, Alahmari S. Exploring skin picking disorder: Aetiology, treatment, and future directions. Postepy Dermatol Alergol 2024; 41: 545–551.

2. Ansari MN, Bragg BN. Delusions of parasitosis. StatPearls Publishing; 2023
3. Assalman I, Ahmed A, Alhajjar R, Bewley AP, Taylor R. Treatments for primary delusional infestation. Cochrane Database Syst Rev 2019; 12: CD011326.
4. Basfar L, Almadfaa A, Nazer BA, Al Hawsawi K, Khayyat ST. Dermatitis artefacta: A challenging case report. Cureus 2023; 15: e34244.
5. Browne HA, Gair SL, Scharf JM, Grice DE. Genetics of obsessive-compulsive disorder and related disorders. Psychiatr Clin North Am 2014; 37: 319–335.
6. Brownstone N, Howard J, Koo J. Management of delusions of parasitosis: An interview with experts in psychodermatology. Int J Womens Dermatol 2022; 8: e035.
7. Carlini SV, Greenstein SP, Jimenez X. Delusional Parasitosis Following COVID-19: A Case Report. J Acad Consult Liaison Psychiatry 2022; 63: 511–512.
8. Cerejeira A, Gomes N, Cruz M, Mota A, Azevedo F. Dermatitis artefacta. Dermatol Online J 2021; 27: 13030/qt7 p92b04t.
9. Chandran V, Kurien G. Dermatitis artefacta. StatPearls Publishing; 2022.
10. Christensen RE, Tan I, Jafferany M. Recent advances in trichotillomania: a narrative review. Acta Dermatovenerol Alp Pannonica Adriat 2023; 32: 151–157.
11. Ciccarese G, Salvia G, Fidanzi C, Mastrolonardo M, Drago F. Dermatitis artefacta: a challenging diagnosis. Dermatol Reports 2024. 10.4081/dr.2024.10014.
12. Coetzee S, Mahajan C, França K. The diagnostic workup, screening, and treatment approaches for patients with delusional infestation. Dermatol Ther (Heidelb) 2023; 13: 2993–3006.
13. Eskeland SO, Moen E, Meland KJ, Andersen A, Hummelen B. Skin picking disorder. Tidsskr Nor Laegeforen 2021; 141
14. Ferreira BR, Jafferany M. Classification of psychodermatological disorders. J Cosmet Dermatol 2021; 20, 1622–1624
15. Ferreira BR, Vulink N, Mostaghimi L, Jafferany M, Balieva F, Gieler U, Poot F, Reich A, Romanov D, Szepietowski JC, Tomas-Aragones L, Campos R, Tausk F, Zipser M, Bewley A, Misery L. Classification of psychodermatological disorders: Proposal of a new international classification. J Eur Acad Dermatol Venereol 2024; 38: 1213-1214
16. França K, Kumar A, Castillo D, Jafferany M, Hyczy da Costa Neto M, Damevska K, Wollina U, Lotti T. Trichotillomania (hair pulling disorder): Clinical characteristics, psychosocial aspects, treatment approaches, and ethical considerations. Dermatol Ther 2019; 32: e12622.
17. Freudenmann RW, Lepping P. Delusional infestation. Clin Microbiol Rev 2009; 22: 690–732
18. Gajbhiye A, Ali T, Aziz S, Singh P, Gandhi S, Chaudhury S, Patil J. Delusional parasitosis: A case series. Ind Psychiatry J 2023; 32: S258–S261
19. Gattu S, Rashid RM, Khachemoune A. Self-induced skin lesions: A review of dermatitis artefacta. Cutis 2009; 84: 247–25
20. Goldin D, Salani DA, Valdes B. N-acetylcysteine (NAC) for trichotillomania and excoriation disorder: An overview. J Psychosoc Nurs Ment Health Serv 2025; 0: 1–9
21. Grant JE, Chamberlain SR. Prevalence of skin picking (excoriation) disorder. J Psychiatr Res 2020; 130: 57–60.
22. Grant JE, Chamberlain SR. Trichotillomania. Am J Psychiatry 2016; 173: 868–874.
23. Grant JE, Collins M, Chesivoir E, Chamberlain SR. Suicidal ideation and attempts in trichotillomania. Psychiatry Res 2023; 325: 115245.
24. Grant JE. Trichotillomania (hair pulling disorder). Indian J Psychiatry 2019; 61: S136–S139.
25. Halvorsen MW, Garrett ME, Cuccaro ML, Ashley-Koch AE, Crowley JJ. Genomic analysis of trichotillomania. Am J Med Genet B Neuropsychiatr Genet 2025; e33035.
26. Jafferany M, Franca K. Psychodermatology: Basics Concepts. Acta Derm Venereol 2016; 96: 35–37
27. Jafferany M, Patel A. Therapeutic aspects of trichotillomania: A review of current treatment options. Prim Care Companion CNS Disord 2018; 20: 18nr02344.
28. Jafferany M. Psychodermatology: a guide to understanding common psychocutaneous disorders. Prim Care Companion J Clin Psychiatry 2007; 9: 203–213
29. Katamanin O, Jafferany M. Psychological interventions in the treatment of delusional parasitosis: A brief review. Int J Dermatol 2024; 63: 580–584.
30. Kemperman PMJH, Bruijn TVM, Vulink NCC, Mulder MMC. Drug-induced delusional infestation. Acta Derm Venereol 2022; 102: adv00663.
31. Kim SH, Lee JI, Park S, Paek SH. Acute abdominal pain with obstructing trichobezoar: A pediatric case of Rapunzel syndrome diagnosed in a pediatric emergency department. Pediatr Rep 2025; 17: 53.
32. Knapp B, Tito E, Espiridion ED. Delusional parasitosis in a patient with alcohol-induced psychotic disorder. Cureus 2019; 11: e4344.
33. Koo JY, Lee CS. General approach to evaluating psychodermatological disorders. In: Koo JY, Lee CS, editors. Psychocutaneous medicine 2003; 1–29.

34. Krzyszkowiak W, Kuleta-Krzyszkowiak M, Krzanowska E. Treatment of obsessive-compulsive disorders (OCD) and obsessive-compulsive-related disorders (OCRD). Psychiatr Pol 2019; 53: 825–843.
35. Lee DK., Lipner SR. The potential of N-acetylcysteine for dermatologic conditions. J Drugs Dermatol 2022; 21: 370–376.
36. Lochner C, Roos A, Stein DJ. Excoriation (skin-picking) disorder: a systematic review of treatment options. Neuropsychiatr Dis Treat 2017; 13: 1867–1872.
37. Melo DF, Lima CDS, Piraccini BM, Tosti A. Trichotillomania: What Do We Know So Far?. Skin Appendage Disord 2022; 8: 1–7.
38. Modanlo N, Yan X, Bourgeois JA. Pharmacologic Management of Skin-Picking Disorder: An Updated Review. J Acad Consult Liaison Psychiatry 2025.
39. Monzani B, Rijsdijk F, Harris J, Mataix-Cols D. The structure of genetic and environmental risk factors for dimensional representations of DSM-5 obsessive-compulsive spectrum disorders. JAMA psychiatry 2014; 71: 182–189.
40. Mostaghimi L, Noughani H. 'Psychodermatology': The present standing and a path forward. J Eur Acad Dermatol Venereol 2022; 36: 1162–1163.
41. Mostaghimi L. Promoting Psychodermatology; too few Psychocutaneous articles in leading dermatology journals. J Eur Acad Dermatol Venereol 2023; 37: e380–e381.
42. Mukundu Nagesh N, Barlow R, Mohandas P, Gkini MA, Bewley A. Dermatitis artefacta. Clin Dermatol 2023; 41: 10–15.
43. Mumcuoglu KY, Leibovici V, Reuveni I, Bonne O. Delusional Parasitosis: Diagnosis and Treatment. Isr Med Assoc J 2018; 20: 456–460.
44. Nina Domínguez L, Imbernón-Moya A, Saceda-Corralo D, Vañó-Galván S. Trichotillomania Treatment Update. Actas Dermosifiliogr 2025; 116: T152–T158.
45. Novak CE, Keuthen NJ, Stewart SE, Pauls DL. A twin concordance study of trichotillomania. Am J Med Genet B Neuropsychiatr Genet 2009; 150B: 944–949.
46. Ochiai S, Sugawara H, Kajio Y, Tanaka H, Ishikawa T, Fukuhara R, Jono T, Hashimoto M. Delusional parasitosis in dementia with Lewy bodies: a case report. Ann Gen Psychiatry 2019; 18: 29.
47. Ravipati P, Conti B, Chiesa E, Andrieux K. Dermatillomania: Strategies for Developing Protective Biomaterials/Cloth. Pharmaceutics 2021; 13: 341.
48. Reess TJ, Rus OG, Schmidt R, de Reus MA, Zaudig M, Wagner G, Zimmer C, van den Heuvel MP, Koch K. Connectomics-based structural network alterations in obsessive-compulsive disorder. Transl Psychiatry 2016; 6: e882.
49. Reich A, Kwiatkowska D, Pacan P. Delusions of Parasitosis: An Update. Dermatol Ther (Heidelb) 2019; 9: 631–638.
50. Reid M, Lin A, Farhat LC, Fernandez TV, Olfson E. The genetics of trichotillomania and excoriation disorder: A systematic review. Compr Psychiatry 2024; 133: 152506.
51. Rodríguez Pichardo A, García Bravo B. Dermatitis artefacta: a review. Actas Dermosifiliogr 2013; 104: 854–866.
52. Rodriguez-Vallecillo E, Woodbury-Fariña MA. Dermatological manifestations of stress in normal and psychiatric populations. Psychiatr Clin North Am 2014; 37: 625–651.
53. Roos A, Fouche JP, Stein DJ, Lochner C. Structural brain network connectivity in trichotillomania (hair-pulling disorder). Brain Imaging Behav 2023; 17: 395–402.
54. Ryan MP, Wagner RF. Psychodermatology fellowship: is it time? Dermatol Online J 2021; 27: 13030/qt7j15s8kh.
55. Sani G, Gualtieri I, Paolini M, Bonanni L, Spinazzola E, Maggiora M, Pinzone V, Brugnoli R, Angeletti G, Girardi P, Rapinesi C, Kotzalidis GD. Drug Treatment of Trichotillomania (Hair-Pulling Disorder), Excoriation (Skin-picking) Disorder, and Nail-biting (Onychophagia). Curr Neuropharmacol 2019; 17: 775–786.
56. Schienle A, Wabnegger A. Structural neuroimaging of skin-picking disorder. Prog Neuropsychopharmacol Biol Psychiatry 2024; 133: 111024.
57. Singh S, Chikhalkar S, Kabbannavar YR. Dermatitis artefacta: A diagnostic dilemma. Indian J Psychiatry 2023; 65: 703–705.
58. Torales J, Díaz NR, Barrios I, Navarro R, García O, O'Higgins M, Castaldelli-Maia JM, Ventriglio A, Jafferany M. Psychodermatology of skin picking (excoriation disorder): A comprehensive review. Dermatol Ther 2020; 33: e13661.
59. Torales J, Malvido K, Vázquez MA, Barrios I, Almirón-Santacruz J, Navarro R, O'higgins M, Casas G, Castaldelli-Maia JM, Ventriglio A, González-Urbieta I. Dermatitis Artefacta: A Practical Guide for Diagnosis and Management. Acta Dermatovenerol Croat 2023; 31: 17–23.
60. Wong JW, Nguyen TV, Koo JY. Primary psychiatric conditions: dermatitis artefacta, trichotillomania and neurotic excoriations. Indian J Dermatol 2013; 58: 44–48.