DERMIS

Review Article 2025; 5(5):48

Dermatologic Patterns and Psychological Drivers of Factitious Dermatitis in Adolescent Females

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Received : July 14, 2025
Published : September 09, 2025

ABSTRACT

Factitious dermatitis in adolescent females presents a dermatologic enigma characterized by self-induced skin lesions that mimic inflammatory, autoimmune, and infectious dermatoses, complicating timely diagnosis and intervention. The condition often manifests as sharply demarcated, geometric, or angulated plaques, erosions, and ulcerations in accessible areas such as the face, arms, and legs, with a predilection for sparing traditionally seborrheic or flexural regions. Lesions frequently exhibit an artificial, non-inflammatory border with varying stages of healing, often incongruent with reported symptom progression. Repetitive excoriation, occlusion-based maceration, and exposure to irritants or topical caustics contribute to an evolving dermatitic phenotype, ranging from lichenified plaques resembling chronic atopic dermatitis to erosive dermatitis artefacta. Given the tendency for patient concealment and non-admission, differentiation from atopic, contact, and neurotic excoriation disorders requires thorough clinical correlation, supported by dermatoscopic and histopathologic findings such as epidermal necrosis, lack of inflammatory cell infiltration, and absence of characteristic spongiotic or psoriasiform changes. The psychosocial underpinnings often linked to stress, anxiety, body dysmorphia, and perfectionistic tendencies necessitate a dual approach integrating dermatologic intervention with psychotherapeutic support. Management strategies include barrier-repairing emollients with occlusive properties to mitigate recurrent trauma, alongside structured behavioral interventions such as cognitive-behavioral therapy (CBT)-guided skin protection protocols. As adolescent mental health concerns surge, dermatologists must refine their diagnostic

DOI: https://doi.org/10.35702/Derm.10048

acumen and therapeutic strategies to bridge the gap between dermatologic precision and the nuanced psychological drivers of factitious dermatitis, fostering both skin barrier restoration and long-term behavioral modification.

Keywords: Factitious Dermatitis, Self-Inflicted Skin Lesions, Psychocutaneous, Morphology, Psychodermatology, Cognitive-Behavioral Therapy, Multidisciplinary Management

INTRODUCTION

Factitious dermatitis (FD), also referred to as dermatitis artefacta, is a self-inflicted dermatologic condition characterized by the deliberate production of dermatologic lesions. It is classified under the category of psychodermatologic disorders, specifically as a primary psychiatric disease affecting the skin. The associated skin damage ranges from excoriations, abrasions, and blisters to deep ulcers and secondary skin infections. According to the DSM-5-TR, factitious disorders are categorized under "somatic symptom and related disorders," a category that also includes non-self-inflicted lesions such as burning mouth syndrome and vulvodynia [1]. Efforts by international organizations aim to unify existing classification systems across the DSM-5, ICD-11, and psychiatric and dermatologic literature, to clarify the often-blurred boundaries within psychodermatology and, as a result, improve their clinical management [2].

FD is particularly relevant to the adolescent population, with a larger predominance among adolescent females. A 2005 retrospective analysis of 57 patients found that a diagnosis of FD was 2.8 times more common in females than males, with an age range spanning 18 to 60 years [3]. However, more recent studies suggest that the highest prevalence of FD occurs during adolescence and early adulthood [4,5]. This is likely due to the onset of self-injurious dermatologic behaviors during a developmental period marked by emotional volatility and heightened psychosocial stressors.

The clinical relevance of FD lies at the intersection of dermatology and psychiatry, emphasizing the need for interdisciplinary collaboration. Dermatologists often serve as the initial point of contact for patients with unexplained or atypical lesions, yet the psychiatric underpinnings may go unrecognized without adequate training in psychodermatology. In a recent study by Sun et al., children presenting with FD are at a 4.13-fold increased risk of developing psychiatric illness, with common comorbidities including anxiety, attention-deficit/hyperactivity disorder (ADHD), obsessive-compulsive disorder (OCD), and depression. Moreover, over 80% of patients with FD were found to have an underlying psychiatric diagnosis [6]. This reinforces the importance of integrating psychiatric or mental health evaluations into dermatologic care, and, as such, increasing awareness of psychodermatology conditions among dermatologists is essential for comprehensive patient-centered care.

This comprehensive review aims to provide an updated, interdisciplinary overview of the literature on factitious dermatitis, with a focus on its presentation in adolescent populations. By consolidating current literature on its clinical features, epidemiology, diagnostic challenges, and management strategies, this review seeks to enhance clinician awareness and promote integrated care models between dermatology and psychiatry. Additionally, we examine recent efforts to unify classification frameworks, advocating for improved diagnostic clarity and timely, effective intervention.

REVIEW

Dermatologic Features of Factitious Dermatitis

Factitious dermatitis (FD), or dermatitis artefacta, is a psychocutaneous disorder that presents with a broad spectrum of cutaneous findings that reflect self-inflicted injury. It most commonly occurs in late adolescence and early adulthood, with a marked predilection for females [7]. Lesions in FD are self-inflicted through a wide range of mechanical or chemical means, including scratching, pinching, picking, suctioning, or using sharp or blunt objects, as well as burns from cigarettes or lighters or the injection/application of caustic substances [8,9]. The underlying reasons for self-infliction or injury are often psychiatric, as will be explored in a subsequent section. Clinically, factitious dermatitis lesions often exhibit distinct morphologic patterns that, when assessed alongside the patient's history and behavior, can increase suspicion for this diagnosis.

Clinical Morphology

The appearance of lesions in factitious dermatitis (FD) varies due to the range of instruments or methods used for self-infliction. These lesions exhibit distinctive "bizarre" shapes, ranging from geometric and angular to necrotic or linear, with a sharp demarcation from surrounding normal skin [10,11]. The distribution of these lesions is also variable, with solitary or multiple lesions commonly found on accessible areas of

the body, such as the face, upper torso, and extensor surfaces of the extremities [3]. These areas are easily within reach for self-inflicted injury. Additionally, FD lesions may evolve with multiple morphologic types presenting simultaneously. Common features include erosions, ulcerations, ecchymoses, excoriations, panniculitis, and, in some instances, bullae or eschars [10]. Secondary features like lichenification, post-inflammatory hyperpigmentation, and scarring are present in chronic cases [12]. This polymorphic presentation with lesions of varying age and stages of healing is an important clinical diagnostic clue that warrants further evaluation.

Dermatoscopy and Histopathology

Although dermatoscopy and histopathology can help support a diagnosis of factitious dermatitis (FD), both modalities yield nonspecific findings that must be carefully interpreted within the broader clinical context. Dermoscopic features of FD can show red blotching, indicative of capillary leakage, and yellow crusting, a sign of serum exudation due to excoriation [13]. These features are generally associated with trauma rather than a primary dermatosis. However, dermoscopy alone provides limited diagnostic information.

In contrast, histopathology reveals a broader range of changes. However, the findings depend on the method and timing of self-inflicted injury. Common histopathological findings include mild, acute inflammation, an increased presence of polymorphonuclear leukocytes, scattered erythrocytes, and areas of epidermal necrosis with fibrocystic reaction [14]. Additionally, ruptured collagen fibers, multinucleated keratinocytes, and vertically aligned or elongated keratinocytic nuclei have been reported in some cases [15]. Some studies have identified more specific patterns related to the method of injury. For example, necrotic zones sharply demarcated from uninvolved epidermis with elongated keratinocytes resemble thermal or electrical artifacts [16]. However, the existing literature on histopathologic findings remains limited, whereby only a few studies, as above, have characterized the histological features of FD. As such, the interpretation of these findings is complicated by the inability to confirm the exact mechanism of injury, and histopathology serves to rule out other inflammatory or infectious dermatoses. Nevertheless, dermoscopic and histopathologic findings can provide valuable clues to differentiate factitious dermatitis from other inflammatory conditions.

Table 1. Key Features of Factitious Dermatitis

Lesion Morphology	Varying shapes and distributions with sharp demarcation from surrounding normal skin • Evolution: polymorphic lesions presenting simultaneously (different healing stages) • Common features: erosions, ulcerations, ecchymoses, ulcerations
Lesion Location	"Accessible" areas of the body (i.e., face, upper torso, upper extremities)
Dermatoscopy	Non-specific findings including red blotching and yellow crusting
Histopathology	Increased polymorphonuclear leukocytes, scattered erythrocytes, epidermal necrosis with fibrocystic reaction

Differentiation from Common Dermatologic Mimickers

Factitious dermatitis (FD) is frequently considered a diagnosis of exclusion, as its lesions can resemble those of other chronic inflammatory and dermatologic conditions [17]. Patients may be reluctant to admit their role in the creation of the lesions, complicating the diagnosis. Therefore, FD should be included in the differential diagnosis for recurrent dermatoses. Both dermatologic and psychiatric differentials must be considered. One common mimicker is neurotic excoriations, which differ from FD in that patients typically recognize their involvement in causing the lesions, often preceded by a sensation of pruritus [18]. Other conditions that mimic FD, as reported in various case reports, include necrotizing vasculitis [19], bullous skin disease [20], pyoderma gangrenosum [21], and vasculitis [22]. Additionally, herpes simplex infection, allergic/irritant contact dermatitis, porphyria cutanea tarda, alopecia areata, drug eruptions, impetigo, and insect bites should also be considered in the differential diagnosis [7]. Ultimately, a thorough clinical evaluation and consideration of both dermatologic and psychiatric factors are essential to differentiate factitious dermatitis from its many mimickers.

DOI: https://doi.org/10.35702/Derm.10048

Psychosocial and Psychiatric Drivers of Factitious Dermatitis

Psychological Considerations

The psychological basis of factitious dermatitis (FD) is multifactorial, often rooted in emotional dysregulation and maladaptive coping mechanisms. Patients may experience chronic depression, 118 anxieties, perfectionistic traits, and body dysmorphic concerns, all of which contribute to self-injurious behaviors such as self-inflicted dermatoses. In a recent cohort study, pediatric patients diagnosed with FD were found to be 4.3 times more likely to receive a psychiatric diagnosis within the next year [6]. Frequently associated comorbidities include anxiety disorders, obsessive-compulsive disorder (OCD), attention-deficit/hyperactivity disorder (ADHD), and depressive disorders, with patients often using self-inflicted lesions as a maladaptive mechanism to alleviate psychological discomfort or regain a sense of control in a chaotic emotional environment [23]. In such individuals, FD may symbolize emotional suffering that is difficult to articulate. Perfectionism and body dysmorphic disorder (BDD), both disproportionately affecting adolescent females, are additional notable psychiatric comorbidities that may further contribute to the development of FD. In these individuals, an intense preoccupation with perceived physical flaws can lead to compulsive manipulation of the skin, especially in cosmetically sensitive areas such as the face or arms [23]. Attempts to "correct" these flaws can become compulsive, leading to persistent excoriation or chemical injury, sustaining the self-injurious cycle.

Control-seeking behaviors are another prominent feature of FD, particularly in patients navigating unstable interpersonal or familial environments. In such cases, inducing and controlling a lesion's evolution may provide a perceived sense of empowerment or agency [24]. This behavior may be inadvertently reinforced through increased attention or care from others, constituting a form of secondary gain [25]. Thus, FD should be understood not merely as a dermatologic or behavioral issue, but as a complex manifestation of deeper psychological distress, one that necessitates comprehensive psychiatric evaluation and long-term psychological support.

Developmental Considerations

Adolescence is a formative developmental period marked by profound biological, psychological, and social transitions. During this stage, individuals often struggle with identity formation, autonomy, and navigating peer and family relationships. FD in adolescents often reflects internalized distress associated with these transitions. Peer dynamics, including bullying, social exclusion, and the desire for social acceptance, may precipitate somatic expressions of psychological suffering. In such contexts, visible lesions may function as a subconscious plea for connection, sympathy, or validation [26].

Family dynamics further compound these developmental challenges. Emotional neglect, inconsistent parenting, overbearing parental control, or poor communication may contribute to the development of FD. Adolescents in these settings may seek alternative outlets, such as repetitive scratching, picking, or friction rubbing, to externalize unmet emotional needs [27]. These behaviors, in turn, can provoke a caregiving response from family or friends, thereby reinforcing patterns of secondary gain.

Beyond the complexity of familial and peer relationships, the digital environment, particularly social media, plays an increasingly prominent role in adolescent psychosocial development [28]. Pervasive exposure to idealized images and unrealistic beauty standards on social media platforms can distort self-perception and heighten vulnerability to disorders, including FD. Additionally, online bullying or identity-based harassment may intensify feelings of isolation or inadequacy. Together, these developmental pressures during adolescence can exacerbate psychological distress, with the emergence of FD serving as an outward manifestation of this internal struggle.

Diagnostic Challenges and Ethical Considerations

The diagnosis of FD presents unique clinical challenges due to deliberate concealment, inconsistent histories, and the psychologically complex nature of the condition. Patients frequently deny awareness of how their lesions developed or offer vague explanations that are inconsistent with the clinical presentation [28]. A diagnostic clue that many patients with FD exhibit is the presence of la belle indifférence, a disproportionate lack of concern for lesions that would typically be perceived as distressing or disfiguring [29,30]. This presentation of emotional detachment is subtle, often underrecognized, or easily overlooked in dermatologic settings.

Central to the effective management of patients with FD is the development of a strong therapeutic alliance. Building trust within the physician-patient relationship and creating a safe, nonjudgmental environment are essential for promoting treatment adherence and encouraging openness to multidisciplinary interventions, particularly those psychotherapeutic in nature. A careful and thorough history is also just as important, as discrepancies between clinical findings and the patient's reported symptoms, or a failure to respond to conventional treatments, may raise suspicion for FD and guide further evaluation. Direct confrontation regarding the self-inflicted nature of lesions can threaten the therapeutic alliance, particularly in the absence of trust or a strong patient-provider relationship [27]. Such encounters risk alienating the patient or provoking escalated self-harm. Instead, clinicians are recommended to reframe discussions around the impact of stress or emotional distress on their skin condition [17,31]. This approach can help initiate broader psychiatric or psychotherapeutic involvement.

Clinicians must also balance diagnostic clarity with ethical sensitivity. Disclosing the suspected diagnosis of FD prematurely or mishandling psychiatric referrals may provoke resistance or disengagement, particularly in patients who minimize their emotional distress or reject mental health interventions [31]. Given these challenges, a multidisciplinary approach that integrates dermatologic expertise with psychiatric support is essential. Collaboration between dermatologists, psychiatrists, psychologists, and ancillary support systems will enable early recognition of FD and associated psychiatric comorbidities and reduce maladaptive disease-related behaviors [32]. Without this, treatment is often hindered by nonadherence, refractory treatments, repeated medical interventions, and more severe outcomes like unnecessary surgical procedures [33]. Such collaboration not only facilitates accurate diagnosis but also provides a safe and supportive environment in which patients can begin to address the underlying psychological distress driving their behaviors. Ultimately, an integrated dermatology-psychiatric framework remains key to improving outcomes in this challenging patient population.

Multimodal Management

Dermatologic Management

The dermatologic management of FD is multifactorial, focusing on minimizing further skin trauma, promoting wound healing, restoring the skin barrier, reducing inflammation, and preventing secondary infection. Emollients and barrier-repair agents help repair the skin's integrity. Similarly, occlusive dressings serve a dual purpose by aiding in wound healing and limiting patient access to affected areas, protecting them from further trauma. Careful observation of the patient, combined with the use of emollients, occlusive techniques, and topical antibiotics when indicated, has been shown in multiple cases to yield favorable outcomes [17,34]. Depending on the characteristics of the cutaneous lesions, topical corticosteroids or alternatives like calcineurin inhibitors can be utilized to mitigate inflammation in the affected areas [35]. Additional interventions, including debridement, irrigation, systemic antibiotics, or antifungal therapy, may be necessary for the management of complicated or infected wounds [36]. Ultimately, dermatologic treatment strategies for FD should be individualized, considering the extent and severity of the lesions.

Psychotherapeutic Management

The psychotherapeutic management of FD is equally as important and centers on addressing the underlying psychological and behavioral drivers of the self-inflicted behavior. Behavioral therapy has demonstrated efficacy in the management of FD. For instance, cognitive behavioral therapy (CBT) helps patients identify and modify maladaptive thoughts and behaviors contributing to self-inflicted lesions. In addition to CBT, habit reversal training (HRT) is also useful in disrupting the cycle of compulsive behaviors [37,38]. In more complex cases, dialectical behavioral therapy (DBT), a form of CBT emphasizing emotional regulation and distress tolerance, has demonstrated success in reducing stress and improving coping in cases of FD [39,40]. Furthermore, family therapy and school-based interventions can further reduce external stressors contributing to the patient's maladaptive behaviors. For instance, family therapy can be used to address dysfunctional family dynamics, and school-based interventions can be beneficial in providing a supportive psychosocial environment to reinforce treatment goals.

Despite these interventions, psychiatric comorbidities can be underrecognized due to the patients' denial of psychological distress and reluctance to engage with psychiatric services [41]. In these cases, the use of psychiatric drugs, such as selective serotonin reuptake inhibitors (SSRIs) or atypical antipsychotics, could be appropriate [31,42,43]. It is important

DOI: https://doi.org/10.35702/Derm.10048

to practice caution when prescribing SSRIs to patients with FD who have comorbid borderline personality disorder, as it can lead to severe mood dysregulation [44]. Ultimately, the combination of behavioral therapy and pharmacologic intervention, when appropriate, would be the most effective approach to psychotherapeutic management of FD, a combination that is well-supported by the literature on the treatment of complex psychiatric disorders.

Table 2. Multimodal Management Approach for Factitious Dermatitis in Adolescents

Step	Focus	Key Actions
1	Initial Evaluation	• Comprehensive skin exam to evaluate lesion morphology • Dermatoscopy/histopathology • Rule out clinical mimickers
2	Building Rapport	Explore the stress-skin connection, avoid confrontation
3	Dermatologic Management	Emollients, occlusive dressings, topical steroids, and infection prevention
4	Psychotherapeutic Support	CBT, HRT, DBT, family therapy, school-based interventions
5	Pharmacologic Management	SSRI (*except in unstable bipolar disorder*) Antipsychotics for severe behavioral dysregulation
6	Ongoing Collaboration	Multi-disciplinary follow-up (dermatology, psychiatry, and/or psychology) • Track lesion recurrence • Monitor coping mechanisms and emotional well-being • Adjust interventions

CBT: Cognitive-Behavioral Therapy. HRT: Habit-Reversal Training. DBT: Dialectical Behavioral Therapy. SSRI: Selective Serotonin Reuptake Inhibitors.

Emerging Insights and Future Directions

Importance of Interdisciplinary Derm-Psych Collaborations

Psychodermatology bridges the gap between dermatology and psychiatry by addressing the psychological underpinnings and emotional consequences of skin disease [45]. This creates a multidimensional level of care that goes beyond the surface-level treatment of the visual aspects of the disease. Conditions such as atopic dermatitis (AD), psoriasis, vitiligo, and alopecia areata involve complex feedback loops between psychosocial or emotional stress, which leads to increased psychiatric comorbidities like depression and anxiety, and skin manifestations [46]. Psychological distress can exacerbate dermatology symptoms, while visible skin disease can, in turn, heighten anxiety and depression, driving coping behaviors like scratching or skin picking [47]. These aspects of mental health often led to a delay in seeking expert consultation and help for these dermatologic conditions, creating a cyclical effect that encompasses the negative outcomes of diseases under the realm of psychodermatology. This is particularly relevant in adolescents, whose vulnerability to psychiatric comorbidities can complicate diagnosis and delay effective treatment. Despite this, psychodermatology remains underutilized in routine clinical settings, underscoring the need for integrated collaboration and improved screening techniques for factitious diseases in dermatology, including FD.

There is a dynamic, reciprocal relationship between the skin and nervous system: the skin sends various signals to the nervous system, which then influences the nervous system and mind to affect the skin. Psychodermatoses are broadly categorized into three groups. The first group is skin conditions caused by direct psychiatric disorders, which lead to self-inflicted lesions, including factitious dermatitis (FD) and excoriated acne. The second group is dermatologic disease exacerbated by psychological stressors involving

incidents that lower the immune system, leading to psoriasis, herpes simplex virus reactivations, and vitiligo. The final group is proposed to be caused by mutual influence, which leads to skin conditions that are worsened or sustained by psychological stress [45]. A differentiated understanding of these three groups of psychodermatoses allows for proper identification and targeted management of conditions that go beyond the surface level of the skin.

The goal of dermatology-psychiatric collaboration extends beyond treating the visible dermatologic condition. It involves empowering patients with the education and psychological tools needed to manage chronic illness through mental resilience and adaptive coping strategies [48]. This holistic approach enhances motivation to seek further treatment, fosters acceptance of early treatment failures, and supports patients in becoming comfortable in their skin, regardless of the condition they present with. As such, dermatologists should routinely assess for underlying mental or emotional stressors that may accompany their patients' skin conditions during clinical evaluations in the office [45]. This suggests the integration of mental health into standard dermatologic assessments. A 2024 systematic review assessing the effectiveness of interdisciplinary psychodermatology across 12 countries reported an 87% improvement in patient outcomes and care coordination, including reductions in cost, improved access, and increased clinical knowledge [49]. Overall, at the core of psychodermatology models is a strong patient-physician relationship, which creates space for necessary dialogue around the underlying issues that may potentially be leading to skin conditions or exacerbating them. This integrated framework not only enables more targeted treatment but also contributes to shorter, more effective treatment courses and improvements in overall quality of life.

Gaps in the Literature

Despite increased recognition of psychodermatology and psychodermatologic conditions, substantial gaps remain in the literature on FD in adolescents. Underreporting and misdiagnosis (often as atopic dermatitis) contribute to limited data on the true prevalence and treatment efficacy for FD [50]. Additionally, there is also the element of difficulty that dermatologists may have when approaching patients, particularly younger patients with their family members in the exam room, about delicate psychological subjects. These conversations are often constrained by discomfort or simply not knowing how to navigate these discussions in a dermatologic setting traditionally focused on the physical symptoms [47]. Compounding these barriers is the scarcity of standardized diagnostic criteria and evidence-based treatment protocols for FD. Managing FD as a purely dermatologic condition risks overlooking its psychosocial drivers, which may lead to persistent symptoms, recurrence, treatment resistance, and potential worsening of the condition. Future research is warranted to develop validated screening tools and age-appropriate interventions tailored to the unique, multifaceted needs of FD patients.

Role of Digital Interventions

Emerging digital interventions hold potential for expanding access to psychodermatology-related care. As discussed earlier, cognitive behavioral therapy (CBT) offers a structured approach to addressing maladaptive coping behaviors, such as skin picking or scratching, by reshaping habits and promoting healthier stress responses. An 8-week digital CBT program for patients with atopic dermatitis in Sweden demonstrated moderate-to-large improvements in quality of life, pruritus, perceived stress, and depressive symptoms related to atopic dermatitis [51]. However, this study had several limitations, including the lack of a control group and a small sample size. Despite this, these results encourage future larger-scale studies assessing the use of digital CBT as an intervention for dermatologic treatment regimens. Digital platforms may also offer stigma-reducing tools for early intervention, especially in adolescents who are comfortable engaging with online resources. School-based mental health interventions and moderated online communities can also provide additional valuable support structures. While still in early stages, the integration of digital CBT or similar models into the field of dermatology offers a path toward more efficient, holistic, accessible care for patients with psychodermatologic conditions.

CONCLUSION

Factitious dermatitis represents a unique clinical and diagnostic challenge at the intersection of dermatology and psychiatry, where self-inflicted lesions manifest as outward expressions of underlying psychological distress. Its diverse morphologic features, polymorphic evolution, and similarity to other inflammatory skin conditions entail a high index of suspicion and comprehensive, multidisciplinary evaluation. While dermatologic assessment, including dermatoscopy

and histopathology, offers important diagnostic clues, these findings should be analyzed alongside a broader psychosocial and behavioral context. Moreover, factitious dermatitis often reflects underlying emotional distress, maladaptive coping strategies, and complex developmental dynamics, particularly in adolescents. Optimal management requires both targeted dermatologic care and the integration of psychotherapeutic interventions to address the psychiatric drivers of self-inflicted injury. Timely recognition is critical to avoid unnecessary medical interventions and facilitate timely psychological support and interdisciplinary care, thereby improving long-term outcomes for this vulnerable patient population.

ACKNOWLEDGEMENTS

None.

CONFLICTS OF INTEREST

The authors declare that there are no conflicts of interest.

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