

NEWS, VIEWS, & REVIEWS

Updates in the Treatment of Body-Focused Repetitive Disorders

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INTRODUCTION

Body-focused repetitive disorders (BFRBs) are psychocutaneous disorders that are underrecognized and undertreated. They are characterized by the performance of a specific body-focused repetitive behavior (eg, hair pulling, skin picking, nail biting, lip biting), repeated attempts to decrease or stop the behaviors by the patient, and resultant clinically significant distress or impairment.[1] Often chronic, BFRBs may lead to medical complications, such as infection or ulceration, and significantly impact patients' quality of life due to physical disfigurement, emotional distress, and social impairment.[1,2] Survey studies have found that most practicing dermatologists report feeling comfortable diagnosing BFRBs, yet report less comfort in successfully treating these conditions and desire more training related to psychocutaneous disorders.[3,4] Herein, we will discuss clinically relevant updates for dermatologists in treating these conditions.

Psychotherapy

BFRBs may be regarded as dysfunctional self-soothing strategies to attenuate negative emotions.[5] Cognitive behavioral therapy (CBT) and its related subtypes are the treatment of choice for BFRBs, particularly trichotillomania and skin picking disorder (SPD).[6,7] CBT involves identifying the situations, feelings, and thoughts that trigger an episode, systematically reducing the associated triggers, and replacing the pleasurable aspect of the unwanted behavior.[8] A 2023 randomized control trial demonstrated that a self-help manual describing habit-reversal training (HRT) and decoupling techniques led to a significant reduction in BFRBs behavior compared to a wait-listed control group (P<0.001).[6] HRT involves reinforcing a new self-soothing routine by replacing the BFRB with a benign repetitive behavior when the urge to engage in BFRB emerges and during symptom-free intervals. This material is available online for free at www.uke.de/free-from-bfrb.

Pharmacotherapy

Currently, no medications are approved by the US Food and Drug Administration for treating BFRBs. Various medications have been studied for off-label treatment of BFRBs, although there remains a paucity of large, randomized controlled trials investigating this topic. In a 2021 systematic review and meta-analysis, there was insufficient evidence to support or reject any single medication as efficacious for the treatment of trichotillomania in adults, children, or adolescents; however, early, yet limited, evidence from trials of N-acetylcysteine (NAC), clomipramine and olanzapine were suggestive of beneficial treatment effects in adults.[9] Similarly, a systematic review of pharmacologic treatment for SPD failed to find substantial evidence to support any specific medication, although few studies met all inclusion criteria before analysis was performed.[10] Another systematic review of the treatment options for SPD found evidence to support pharmacologic treatment with selective serotonin reuptake inhibitors (SSRIs) or NAC.[11]

Recent studies have provided compelling evidence for the beneficial use of glutamatergic agents for treating BFRBs, specifically NAC and memantine, an N-methyl D-aspartate receptor antagonist.

Memantine

A randomized, double-blind, placebo-controlled study of treatment for trichotillomania and SPD with memantine for 8 weeks (titrated from 10 to 20 milligrams [mg] per day at week 2) was found to significantly decrease symptom severity ratings on multiple scales compared to placebo; the calculated number needed to treat was 1.9.[12] Moreover, this was a relatively large study, enrolling 100 subjects. Memantine was well-tolerated, with no serious adverse events reported, although two cases in the memantine group discontinued the trial due to dizziness. One critique of this study is the unusually low placebo rate compared to previous trials studying other medications.[13]

NAC

A retrospective cohort study of treating SPD with NAC found a 61.5% positive response rate among 13 subjects who completed an adequate trial of NAC (minimum 1200 mg total daily for 3 consecutive months, or equivalent dosage); a 46.4% positive response rate was found when analyzing all subjects.[14] Similar, non-statistically significant findings were found in a previous randomized controlled trial.[15] Furthermore, a recent meta-analysis investigating the use of NAC for trichotillomania, SPD, and onychophagia (compulsive nail-biting) found a range of NAC regimens– 600 mg to 3000 mg daily for 0.5 to 10 months– to be a safe and effective treatment.[16] However, a 2022 literature

review concludes that the evidence supporting the beneficial use of NAC for treatment in BFRBs is based upon few trials with small subject sizes and thus should be re-evaluated with larger and longer studies.[17]

Conclusion

BFRBs can develop into chronic conditions if left untreated, potentially causing scarring, ulceration, disfigurement, alopecia, and severe psychosocial impairment. Early diagnosis and treatment can result in symptom reduction in as many as 50% of individuals.[7] Dermatologists play a vital role in recognizing BFRBs as early disease presentations often manifest with skin findings or may be triggered by dermatologic disease.[18] Thus, it is essential for clinicians to remain up-to-date on the management and treatment of BFRBs to prevent long-term disability and morbidity.

Disclosure

The authors declare no conflicts of interest.

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