

## **Dermatillomania, it's time to reveal our scars**

In 2012, when I first started my counselling training, I was still picking and biting the skin around my fingers, an action that embarrassed me and of which I was ashamed. In the past I also used to pick imperfections on my face and back, hiding scabs on my face with make-up, avoiding wearing low back dresses and feeling self-conscious in a swimming costume. Early on in my training I had a client with eczema that she compulsively picked, reminding me of my own predicament, and so I wanted to do further research and complete my counselling Masters dissertation on this topic (Devonald, 2015). My research led me to discover that the condition has a technical name: Dermatillomania (skin picking), and that it belongs to a behavioural group - Body Focused Repetitive Behaviour (BFRB), which is an action performed against an individual's own body. Dermatillomania is a sister condition to Trichotillomania (hair pulling).

Once I started my literature search, I realised that information was minimal and most research was quantitative and medicalised and so I wanted my project to bring the sufferers to the forefront and reflect the felt anguish. I, therefore decided to carry out a heuristic study; an exploratory qualitative approach, advocated by Moustakas (1990). I started with my own experience, looking through old diaries, questioning my thoughts and feelings, interviewing myself, and then worked outwards; reading personal accounts which I found in books (many of which were self published), newspapers and online. I also carried out one skyped unstructured interview with a key sufferer; Canadian Laura Barton. Laura is the author of 'Project Dermatillomania: The stories behind our scars', (2014), which contains international autobiographical accounts. My study asked how sufferers experience, make sense of and treat the condition and highlighted its complexity and severity. Once Laura had given me her story, I owed it to her and the community to help highlight the issue and write an article. I especially wanted to reach fellow therapists, and so I hope this article will improve awareness amongst professionals.

### **Prevalence**

Skin picking is a natural form of grooming, with many people picking at their skin to some extent but for a significant number, this condition becomes problematic and can even be life threatening.

Academic studies suggest between 2 and 5% of the population have the condition (Grant et al, 2012), which is a significant number but as it is very much a silent condition, often perceived as something shameful, I believe this could be higher. Samantha Wake, a sufferer in the UK has done much to raise the profile of Dermatillomania; appearing on '*This Morning*' (2014), writing a blog, having a Face Book group and last summer, speaking at a workshop in London organised by the TLC (Trichotillomania Learning Center, Santa Cruz, California). A Daily Mail article (Wiley and Innes, 2014) about Samantha, resulted in many online comments, with over 50 specifically saying that they themselves had this condition or knew someone who did, one reader writing: '*OMG, i do this! I thought it was just me*'.

### **What is it?**

The Diagnostic and Statistical Manual of Mental Disorders. Fifth edition. DSM-5, (American Psychiatric Association, 2013) gives a definition of 'excoriation', another name for Dermatillomania, and this includes: picking resulting in lesions; attempts to stop or decrease; not due to a medical condition; not due to delusions; causing distress.

Sufferers pick various parts of their bodies, especially the face, hands and torso, picking healthy skin, minor irregularities, pimples and scabs and use fingers, teeth or implements such as tweezers to pick with. It can be very time consuming, Samantha picking for up to 6 hours a day. There are 2 types of picking; automatic and focused, I did both, often not realising I was picking until I saw the results, but especially when picking my face, I was aware I was doing it. Like many others, I found myself in a trance, almost like being mesmerised, reminding me of my knowledge of mindful meditation - using the skin as a focusing anchor, taking the attention away from troublesome thoughts or outside influences. The DSM's definition would certainly have applied to me, but I believe the real definition lies in how much a person is affected by the picking. I have a friend with notable skin damage on his fingers, who was only mildly interested in my project, while other people may have little damage but feel very differently about it.

### **Why don't I know about it?**

What I found was that there is little public awareness of Dermatillomania, leaving sufferers to feel isolated and fearful of disclosure and the media can be sensationalist about it, as Laura suggests, often portraying it as: *'this rare, weird, disorder'*. The reactions of others to the condition are often negative: one comment in the Daily Mail reading: *'Get a grip girl sort yourself and let doctors treat real issues'*. People seem disgusted by it, a reaction I found when discussing my project with others.

### **How does it affect sufferers?**

One of my main findings was the intensity of feelings experienced by sufferers, such as embarrassment, guilt and shame, not only about having the condition, but also the results of the picking and the inability to control it, as Christine Pearson, founder of TLC, puts it: *'the suffocating shame of it all'* (Pearson, 2010, p.10). There are also feelings of abnormality, one Daily Mail reader stating: *'I thought i(sic) was a disgusting freak'* and there can be low self esteem and even self-hate. In my self-interview I describe the condition as: *'something that felt wrong with me, [sighs] something that made me inferior, may be and less of a person'*.

Many sufferers, like me, try and hide the condition with make-up and clothes, or lie about the skin damage; I certainly did, pretending I had eczema on my fingers. Some miss work because of it, avoid social situations and Flessner and Woods found that 54.3% of the 92 in their study refrained from intimate relationships. Angela Hartlin in her autobiographical account 'Forever Scarred', states: *'I'm too revolting, both body and soul, to ever be intimate with another person'*. (Hartlin, 2010, p.127). Luckily for Angela things have improved and she was been given the treatment she needed (by

top expert; Californian based Kate Pickett). Angela is now married and working on her second book detailing her recovery (Hartlin, 2015).

### **What causes it?**

I looked at causes of the condition and found many possibilities. These included; genetic (with many sufferers having family members who also picked); skin conditions (such as acne); or an act of rebellion. I also found that it could be a way to express inner feelings, such as anger; low self esteem and self hatred, Angela describing: *'the bed I lay down in every night has clean sheets spotted sporadically in the depths of my self-hatred'*. (Hartlin, 2010, p.26). Interestingly, I found that some women were picking their most attractive feature and wondered if there was a complex link with beauty: I spoke of *'targeting the best feature of yourself, not wanting to be beautiful'*.

### **Does it serve a function?**

I examined what function, if any, was served by the action, and found this varied for different individuals and also between automatic and focussed picking. Emotional regulation seems likely - with many episodes being preceded by emotional states such as boredom or anxiety. The function, however, could be self-soothing, a distraction, or expression of anger, Grossbart and Sherman suggesting: *'since it is unsafe or unacceptable to feel anger towards others, the skin is elected to take the beating - another way that anger is directed against the self'*, (1992, p.14). Gupta et al (1996), believe individuals to have a defective internal mechanism which means that they cannot regulate emotions, but I wondered, if like Nock et al (2008), researching self-injurious behaviours, whether sufferers actually experience emotions more intensely and so are trying to avoid these feelings, I certainly see myself as a highly sensitive individual. Carrying out the project actually reactivated the condition, taking me to dark places but allowing me to explore it further.

### **Is it compulsive form of self harm?**

The condition appears in the DSM-5 in a new chapter: 'obsessive compulsive and related disorders' but views differ as to whether the condition is impulsive or compulsive, especially with the two types of picking and varying functionality, but the fact it seems to be addictive should be noted.

Some, including my own therapist, see Dermatillomania as a form of self harm but this did not fit with my personal understanding, or Laura's, as the two conditions seem to have different intentions and opposing relationships with control. Laura states that she sees Dermatillomania and self harm as: *'completely different disorders... The intent is different,.. I don't see it as being even close to the same thing, .. if we could do it without injury, we'd still be doing it'*.

### **Can it be treated?**

I went on to examine the research into treatment, looking at suggested medications and available therapy, but also what sufferers have done to help themselves.

One of the issues I found was that many people are too embarrassed to seek help, Neziroglu et al, 2008, finding only 12 of the 40 in their study had sought treatment. Those that do seek help often feel misunderstood by medical professionals, and find

a lack of awareness, Laura stating: *'there are so many people who come online and say 'Oh, I had to tell my doctor about my disorder, they had no idea'. I never sought medical help for my Dermatillomania but did mention it to a psychologist I was seeing for a different condition. I felt her suggestion to wear gloves or sit on my hands, did not recognise the severity of the issue or the bravery it had taken to even talk about it.*

There is some agreement that medication can be of use, but there is also disagreement over which medication.

### **How can therapists help?**

Success has been found from a number of therapeutic approaches such as CBT, Habit Reversal Training (HRT) and Acceptance and Commitment Therapy (ACT) and I am also interested in the use of visualisation, self-hypnosis, breathing and relaxation techniques. Given the complexity of the condition and different forms; automatic and focused, treatment needs to be individualised, but as relapse rates are high and little is known about long lasting effects of treatment, more research needs to be done.

### **What else helps?**

Many, like me, have found their own solutions, in my case gel nails stopped me being able to pick the skin around my cuticles, and others have used breathing techniques, meditations and relaxations, mindful awareness or alternative therapies.

The online community has done much to help themselves, with many individuals sharing their own accounts, which helps them as well as other sufferers by shining light onto the condition. Laura states: *'we've just kind of had enough of all the negativity, the stigma and all that, and now that we have things like the internet we can really .... makes waves with it.'*

One of my major findings was the importance of self acceptance and self love. Laura, although not cured, now has a strong sense of who she is, has learned to live with the condition and wants others to realise that having Dermatillomania does not have to ruin their lives. She states: *'you can live your life and have a happy life and do everything you want to do. 'it's like I'm free of it but I still have it'.*

### **Isn't it a bi-product of another condition?**

Like myself, many sufferers of Dermatillomania are co-morbid, I have also suffered from both depression and anxiety, but I don't think this should detract from the issue and believe that Dermatillomania should be considered a condition in its own right, rather than a bi-product of another better documented one. In fact, many sufferers believe that the Dermatillomania contributed to the other conditions rather than the other way around: Flessner and Woods found that 66.3% of sufferers said that were depressed as a result of Dermatillomania and 85.9% said it caused anxiety. Some sufferers have even considered taking their own lives, because of it; 4 of the 34 in Arnold's survey (1998) felt suicidal because of condition, as one Daily Mail reader states: *'I've had so much shame attached to it to the point of being suicidal many times'.*

### **What else can we do?**

Dermatillomania is a very complex condition that affects people differently, with sufferers varying in where and how they pick and the reasons for picking. Picking may serve differing functions for each individual and how sufferers recover may also vary, meaning that treatment needs to be individualised. More is being published about the condition, and it is hopeful that the future will reveal further solutions, but in the meantime the counselling profession can do more.

- Therapists should consider Dermatillomania as a condition in its own right, even if the client is co-morbid, and recognise the significance of the issue.
- More research is needed, especially into treatment, and in the UK, with more trials using different therapies; I wonder if compassion focused therapy would be a good option.
- More should be done to raise awareness of this condition and other Body Focused Repetitive Behaviours, with more being included in counselling journals and on counselling training courses. I didn't even know it was a condition until I started my research. Let's help Laura and the community make waves.
- Training should be made available to help counsellors work specifically with these issues, colleagues have already come to me for suggestions. Courses currently available in the US should be made available in the UK, for example the use of HRT and ACT.
- Counsellors need to share their experiences of treating sufferers. Perhaps you do already know lots about this condition and have had positive results, may be using less directive approaches, such as the Person Centred. This seems quite likely considering the importance of self acceptance in treatment. Let's have more conversations about it.

Therapist, Linda K Berkeley, recently put out a call for counsellors with knowledge of BFRBs, as she is currently the only UK therapist listed on the TLC website, <http://www.trich.org/index.html>, and wants to compile a list of others. It will be interesting to see how many she finds. Comments by sufferers who have visited therapists suggest a lack of understanding, and so if a client confides to you, that they pick their skin, please think of this article, do not dismiss the comment or consider it benign, but rather remember that it will probably have taken a lot of courage for the person to share this information and your acceptance could be the start of their recovery.

*(Optional - creative synthesis image and comment)*

As part of my dissertation, I produced a creative synthesis, a new whole to show the totality of the condition. This showed the dark interior for the sufferer full of self-hate, embarrassment and despair, but moving out from the darkness is the light, which includes education, therapy, the community, self acceptance and hope.

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