Skin-picking – how can we heal our scars?

Julie Devonald explains the rarely discussed condition of dermatillomania, or skin-picking, and how therapists can help
freak.’ People can have low self-esteem, and even self-hate. In my self-interview I described 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 to 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, and avoid social situations. Flessner and Woods found that 54.3 per cent of the 92 people in their study said it affected intimate relationships.9 Angela Hartlin, in her autobiographical account Forever Marked,10 wrote: ‘I’m too revolting, both body and soul, to ever be intimate with another person.’ Luckily for Angela, things have improved and she has received the treatment she needed, is now married and is working on her second book describing her recovery.11

Causes of skin-picking
I looked at causes of the condition, and found many possibilities. These include genetic (many sufferers have family members who also picked); skin conditions (such as acne), and 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 described how ‘the bed I lay down in every night has clean sheets spotted sporadically in the depths of my self-hatred’.12 Interestingly, I found that some women picked their most attractive feature, and I wondered if there was a complex link with beauty. In my self-interview I talked about ‘targeting the best feature of yourself, not wanting to be beautiful’.

I examined what function, if any, was served by the picking, and found this varied for different people, and also between automatic and focused picking. Emotional regulation seems a likely function – many episodes are preceded by emotional states such as boredom or anxiety. The function, however, could be self-soothing, a distraction, or the expression of anger, as Grossbart and Sherman suggest: ‘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.’13 Gupta and colleagues believe people with dermatillomania have a defective internal mechanism that means that they cannot regulate emotions,14 but I wondered if, as Nock and colleagues found when researching self-injurious behaviours,15 sufferers actually experience emotions more intensely and so are trying to avoid these feelings. I certainly see myself as a highly sensitive person, and the research project actually reactivated the condition, taking me to dark places while also allowing me to explore it further.

The condition is listed in DSM-5 in a new chapter on obsessive-compulsive and related disorders, but views differ as to whether dermatillomania is impulsive or compulsive. That there are the two types of picking and it seems to have a range of functions appears to complicate the distinction, but there is agreement that it seems to be addictive. 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 seem to have different intentions. Laura says 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’.

Treatments
I went on to examine the research into treatment, looking at suggested medications and available therapy, and also what sufferers have found works to help themselves. I found that many people are too embarrassed to seek help. Neziroglu and colleagues found that only 12 of the 40 people in their study had sought treatment.16 Those that do seek help often feel misunderstood by medical professionals, and find a lack of awareness. Laura said: ‘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 professional medical help for my dermatillomania but I 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.

With regard to medication, there is some agreement that it can be of use, but not, as yet, which medication. 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 and breathing and relaxation techniques. Given the complexity of the condition and the different forms (automatic and focused), treatment needs to be individualised. However, relapse rates

References
5. This Morning. I can’t stop scratching my face. [Television]. ITV 2014; 28 May.
are high and little is known about
the lasting effects of treatment.
More research needs to be done.
Many, like me, have found their own
solutions. In my case, gel nails stopped
me being able to pick the skin around
my cuticles. Others have used breathing
techniques, meditation and relaxation,
mindful awareness and alternative
therapies. The online community has
done much to help its members, with
many people sharing their accounts,
which helps them and others by shining
light onto the condition. Laura says:
‘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… make waves with it.’
One of my major findings was the
importance of self-acceptance and
self-love. Laura, although not cured,
says she 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 says:
‘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.’
Like me, many sufferers of
dermatillomania have other conditions.
I have also suffered from both depression
and anxiety, but I don’t think this should
detract from the issue. I believe that
dermatillomania should be considered
a condition in its own right, rather
than a by-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
per cent of sufferers were depressed
as a result of their dermatillomania
and 85.9 per cent said it caused anxiety.
Some sufferers have even considered
taking their own lives because of it: four
of the 34 in Arnold and colleagues’ survey
fled suicidal because of the condition,6
and one Daily Mail reader wrote: ‘I’ve
had so much shame attached to it to
the point of being suicidal many times.’

What else can therapists do?
Dermatillomania is a very complex
condition that affects people differently.
Sufferers vary in how and why they
pick and their reasons for picking.
Picking may serve different 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 to be hoped that
further solutions will be found, but
in the meantime the counselling
profession could do more.
• Therapists should see dermatillomania
as a condition in its own right, even if
the client also has other conditions,
such as depression, and recognise
the significance of the issue.
• More research is needed, especially
into treatment, and especially in the UK,
with more trials of different therapies.
I wonder if compassion-focused therapy
would be a good option.
• More should be done to raise
awareness of the condition and other
BFRBs, with more articles in counselling
journals and information about it 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
are currently available in the US on, for
example, the use of HRT and ACT. These
should be made available in the UK.
• Counsellors need to share their
experiences of treating sufferers.
Perhaps you already know about this
condition and have had positive results
from treating clients, maybe using less
directive approaches, such as person-
centred therapy. This seems quite
likely, considering the importance of
Let’s have more conversations about it.
UK-based therapist Linda K Berkeley
recently put out a call for counsellors
with knowledge of BFRBs, as she is
currently the only therapist from
the UK listed on the TLC website and
she wants to compile a list of others.
It will be interesting to see how many
she finds. Comments by sufferers
who have consulted therapists suggest
a lack of understanding, so if a client
confides to you that they pick their skin,
please think of this article; do not dismiss
the comment or consider the problem
unimportant. 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.

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The TLC website can be accessed at
www.trich.org/index.html

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