Chapter 1

Overview of Body-Focused Repetitive Behaviors

The subject of BFRBs is relatively new to psychology and psychiatry, but it is likely that these problems have been personal issues for as long as humans have had hair to pull and skin to pick. Accounts in the Bible and other ancient sources such as Hippocrates suggest that BFRBs are a universal human phenomenon, occurring across time and cultures (Christenson & Mansueto, 1999). Theoretical views of BFRBs suggest that similar self-damaging patterns related to grooming behavior exist among different species such as mice, birds, cats, dogs, and monkeys as well (Moon-Fanelli, Dodman, & O'Sullivan, 1999). This clinical guide focuses on the two varieties of BFRBs that have now been identified as legitimate psychiatric disorders by the American Psychiatric Association: hair pulling disorder (HPD), also known as trichotillomania, and skin picking disorder (SPD), also known as excoriation disorder. We prefer SPD and HPD to the alternative nomenclature, and we will use these throughout this clinical guide.

What Is Hair Pulling Disorder?

In DSM 5, the current edition of the *Diagnostic and Statistical Manual* (American Psychiatric Association, 2013), HPD is classified as an Obsessive Compulsive and Related Disorder, and the diagnostic criteria are as follows:

- The recurrent pulling out of one's hair results in hair loss.
- The person has made repeated attempts to decrease or stop hair pulling.
- The hair pulling cannot be better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance, such as may be observed in body dysmorphic disorder).
- The hair pulling or hair loss cannot be attributed to another medical condition (e.g., a dermatological condition).
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

In addition to moving HPD from the classification of Impulse Control Disorders to Obsessive Compulsive and Related Disorders, several notable changes in the diagnostic criteria for trichotillomania were also made from the fourth (American Psychiatric Association, 1994) to the fifth edition of the DSM. First, criterion A requiring "noticeable hair loss" was changed to "hair loss." This change was made because many people pull from areas that are not outwardly visible, while others are very careful to hide hair loss. This means that hair pulling individuals without noticeable hair loss had not met criteria for the diagnosis prior to that change. Second, in the fourth edition, criterion B required "an increasing sense of tension immediately before pulling out hair or when attempting to

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resist the behavior." While most people may report experiencing some form of "tension" prior to pulling at least some of the time, most people with HPD may report other experiences such as boredom, anxiety, sadness, frustration, excitement, suspense, guilt, or no notable emotion or tension prior to hair pulling. Criterion B was left out of the fifth edition as it excluded people from being diagnosed who most definitely had a hair pulling problem, just because they did not experience the tension-reduction phenomena. Finally, criterion C from the fourth edition requiring "pleasure, gratification, or relief when pulling out the hair" was also removed from the fifth edition because, like "tension prior to pulling," many people report a wide range of other sensations or emotions, or no particular sensation or emotion at all, prior to pulling out their hair. The changes made in the fifth edition were designed to allow clinicians to more accurately and rationally identify all individuals who warranted inclusion in this diagnostic category.

Hair pulling can occur on any part of a person's body from which hair grows. The most common sites for hair pulling include the scalp, eyelashes, eyebrows, pubic area, arms, legs, and face (for men). Although it may seem awkward to ask specifically about pulling pubic hair, it is important to solicit this information from all clients when doing an intake evaluation. Many people will not report pulling from the pubic area if they are not asked directly about it, most likely because of misguided concerns about presumed sexual connotations associated with that practice. Asking direct questions in a compassionate, nonjudgmental manner serves to reduce shame and embarrassment in clients by helping them feel understood and validated. It is important to uncover the details of the individual pulling styles and behaviors (focused on in Chapter 2) so that an individualized, comprehensive treatment plan can be developed. If key factors that support continued performance of BFRBs go unaddressed, treatment outcome is likely to be disappointing.

What Is Skin Picking Disorder?

Prior to the release of DSM 5 in 2013, skin picking was not included in the American Psychiatric Association's diagnostic system. In this latest iteration of the manual, skin picking, also termed "excoriation disorder," is included among Obsessive Compulsive and Related Disorders with the following diagnostic criteria:

- Recurrent skin-picking, resulting in skin lesions.
- Repeated attempts to decrease or stop skin picking.
- The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The skin picking cannot be attributed to the physiologic effects of a substance (e.g., cocaine) or another medical condition (e.g., scabies).
- The skin picking cannot be better explained by the symptoms of another mental disorder (e.g., delusions or tactile hallucinations [a psychotic disorder], attempts to improve a perceived defect or flaw in one's appearance [body dysmorphic disorder], stereotypies [stereotypic movement disorder], or intention to harm oneself [non-suicidal self-injury]).

There are a host of other BFRB manifestations that are not identified in the DSM 5 classification. These include biting and/or picking of nails, cuticles, lips, the insides of cheeks, severe nose picking, and the grinding of teeth. These behaviors, though not specifically recognized in DSM 5, can be construed as "Other Obsessive Compulsive and

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Related Disorders." Therefore, they may be formally diagnosed and treated, and the ComB approach described in this clinical guide can be easily adapted to treat all these BFRB types.

Differential Diagnoses

Historically, BFRBs have been confused with obsessive compulsive disorder (OCD) or considered to be a symptom or subtype of OCD. Because of this, it is worthwhile to clearly distinguish between the two disorders and to educate clients and other caregivers who may be conflating them. Although OCD and BFRBs have important features in common (they both involve unwanted, repetitive patterns of behavior), there are several notable differences:

1. Obsessive compulsive disorder is typically characterized by obsessions (intrusive thoughts, e.g., "Something bad might happen to me or my loved ones") that increase anxiety, and compulsions (repetitive, voluntary, overt or covert behaviors, e.g., hand washing, checking, mental reassurance, etc.), which serve to reduce the distress associated with the obsession and perhaps belief in the likelihood of harm. In contrast, hair pulling and skin picking are repetitive behaviors that are not likely to be driven by obsessive thoughts (e.g., "If I don't pull my hair something bad will happen to me or my loved one"), and these behaviors are unlikely to function as harm-reduction mechanisms and are less likely to function primarily as anxiety reducers.
2. People with OCD generally abhor their rituals, but they feel compelled to perform them to prevent the feared negative outcome. Conversely, people with BFRBs may experience greater degrees of pleasure or satisfaction from the act of hair pulling or skin picking, but, of course, they are distressed by the longer-term results of their behavior (e.g., baldness, scarring, shame, etc.). Body-focused repetitive behaviors are for many, comforting, soothing, or otherwise rewarding activities that help them feel better, at least in the short term.
3. Treatments for OCD and BFRBs are quite different. The treatment of choice for OCD is exposure and response prevention (ERP). This therapy involves exposing the person to the feared stimuli while requiring them to refrain from performing rituals. The general assumption is that with practice, a person will experience less anxiety with repeated exposure to those stimuli and, as a result, is less inclined to engage in rituals. The expectation is that over time, the obsession will become weaker and functional behavior will increase. Treatment for BFRBs, on the other hand, de-emphasizes ERP and, instead, employs a wider variety of cognitive behavioral techniques designed to provide each individual with capabilities to *decrease their self-damaging practices by substituting adaptive alternatives in their place* (Franklin & Tolin, 2007). Sometimes ERP is included in the framework of ComB treatment when it is deemed appropriate by the clinician; however, it is not the first line intervention for the treatment of BFRBs.
4. Medications that are widely considered as effective for the treatment of OCD typically do not have similar effectiveness for BFRBs. Studies show that the antidepressants known as selective serotonin reuptake inhibitors (SSRIs) are not consistently helpful for people with BFRBs (Chamberlain, Fineberg, & Odlaug, 2012). However, for some individuals, reductions in anxiety, stress, or depressive symptoms may have indirect benefits for people with BFRBs, since these conditions can exacerbate BFRBs for many people. In cases such as these, reducing anxiety or depressive symptoms can have a positive impact on the BFRB. Recent interest has turned to an over-the-counter antioxidant supplement,

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N-Acetyl Cysteine (NAC), that is presumed to impact neurotransmitters through the glutamate system and has shown promise in reducing BFRB severity (Grant, Odlaug, & Kim, 2009). A more comprehensive discussion of medication and nutraceutical interventions for the treatment of BFRBs can be found in Chapter 3.

That said, there is a smaller subset of people with BFRBs who do seem to have a more compulsive "flavor" to their practices. Such individuals may, for example, want to remove every coarse or bumpy hair or they want all pores to be cleaned free of dirt or excoriate. Although these cases are still considered to fall under the purview of BFRBs, they can seem to be more akin to OCD than more typical BFRB forms. In these cases, exposure and response prevention (ERP) can be incorporated into the ComB therapy protocol to help the client become more accepting of unwanted features of the hair or skin. When ERP is employed, it is within the context of the standard ComB assessment and clinical decision-making process that guides the choice of individual treatment components. When and how to incorporate key elements of ERP into the treatment of BFRBs will be discussed in Chapter 10.

Another type of case that may provoke diagnostic confusion would be that of a person who pulls hairs or cuts their hair toward the goal of "evenness" or symmetry (e.g., "Both eyebrows must be identical in form" or "All hairs must be exactly the same length"). In cases such as these, it is important to understand what motives drive the behaviors. What does the person believe will happen or fear will happen if the hair is not all the same length or if the eyebrows do not match? If the answer is something like: "I don't like the way it looks," or "I just want them to match," from the ComB perspective, this is likely to be a form of BFRB that is influenced by factors within the Cognitive and Affective domains ("domains" are integral to the ComB approach and they will be discussed in detail in later chapters). It is common for people with BFRBs to have perfectionistic tendencies about the hair or skin, but sometimes there exists a more generalized personality feature that may require clinical attention and intervention. Moreover, if a person believes that something bad will happen, such as: "A terrible event will occur if my hair isn't all the same length," then the possibility of a primary or comorbid OCD component should be addressed. (Guidance for dealing with comorbidity within the context of ComB treatment will be discussed later in this chapter and at other points throughout this guide.)

Body-focused repetitive behaviors are sometimes confused with body dysmorphic disorder (BDD), and there actually may be some overlap in symptomatology for some BFRB clients. Some individuals report feeling disgusted by the look of certain hairs or by perceived imperfections of the skin and may be convinced that these are so ugly and so intolerable that they must try their best to eliminate them. In some cases, conceptualizing the client as having primary BDD with BFRB features may be warranted. Appropriate treatment would take this into account. Although less common, some hair pulling and skin picking does, in fact, have a more "BDD feel." The ComB model of treatment provides a viable, comprehensive framework with enough latitude and flexibility to accommodate these variations. Appropriate techniques for these purposes are described in Chapter 10.

It is possible that a small subset of people who pick their skin do so with the goal of harming their body, but intentional self-harm is not found within the context of BFRBs. As we will emphasize throughout this guide, BFRBs are viewed as self-regulatory mechanisms that are employed in efforts to *feel better* by meeting an individual's needs on some level – sensory, emotional, or cognitive – not with the intention to

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cause harm or to damage their body. The unfortunate outcome of the BFRB is, of course, damage to the hair or skin, but that is not the intention. Quite the contrary, often an individual pulls or picks with the belief that by engaging in their BFRB they are improving their appearance, even after past experiences have shown otherwise. If, during assessment, it becomes apparent that an individual's skin picking or hair pulling is done with the intent to cause harm to their body, clinical approaches not included in this clinical guide may be required.

Finally, and very rarely, delusional clients may develop a focus on their hair or skin that can masquerade as a BFRB. Hallucinations that involve the belief that insects live under their skin or delusions that there are foreign bodies under their skin can result in attempts to remove these unwanted elements by digging into the skin. Other kinds of delusions can involve beliefs that the removal of, or damage to, some part of the body is necessary, leading to body-damaging practices of various severities. Making the distinction between a BFRB and potentially psychotic conditions is critical in ensuring that treatment is appropriate. As with any differential diagnosis, it is important to conduct an in-depth clinical assessment to determine the true nature of the problem and to follow through with a well-conceived therapeutic plan. Making a premature diagnosis based upon obvious symptoms without performing an adequate functional analysis can lead to improper diagnosis and treatment, and ultimately, frustration for the client and the therapist. As may seem obvious, the broader clinical skills and knowledge of the therapist are often brought to bear in the treatment of BFRBs when there exist complications that the ComB approach is not designed to address.

What We Know about Body-Focused Repetitive Behaviors

As with virtually all legitimate psychological disorders, the assumption is that biological vulnerabilities interact with life experiences to produce the pathology. That is true of BFRBs as well. Here we will briefly cover the research examining genetic components of BFRBs, and also describe the clinical characteristics of hair pulling and skin picking.

Genetic Basis

Although research examining the heritability of HPD and SPD is barely underway, there is some preliminary evidence suggesting that BFRBs have a genetic component. In a family study conducted at Harvard University (Keuthen et al., 2014), researchers reported the incidence of HPD in first-degree family members of their subjects with HPD was 10 percent, while it was just 1–2 percent in first-degree relatives of those without HPD. In addition, rates of skin picking and other BFRBs were higher in relatives of people with HPD. Thus, even if a person with HPD does not have a family member who pulls hair, they are more likely to have someone in their family who bites nails, picks cuticles, bites lips, or picks at acne or scabs than chance alone would allow. It is useful to mention these other BFRBs during client education, as they are generally perceived as less pathological than HPD and therefore place their disorder in a less stigmatized context. More family and genetic research is needed in order to conclude the degree of hereditability of BFRBs. It is useful, however, to present BFRBs as genetically facilitated behaviors, since it changes the perception from that of "willful" practice, to a condition with a biological basis. This kind of information can be helpful in reducing unwarranted shame and embarrassment.

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Age of Onset

The average age of onset for BFRBs is around twelve years old, although these behaviors can begin as early as infancy or much deeper into adulthood. It is not known if this clustering of onset is related to puberty itself and the hormonal changes associated with this period of extensive transformation or due to other factors. Perhaps the emotional turmoil that is common in early teen years may play some role in triggering BFRB symptoms. In people who report a later onset, perhaps in their twenties or thirties, many report having experienced other BFRBs earlier in their lives. For example, a woman who presents for treatment of hair pulling that began when she was 35 years old may also report that, in her early adolescence, she bit her nails and picked at her cuticles. So, although the hair pulling did not start until adulthood, her history with BFRBs actually began in early adolescence, which is in accord with current understanding of BFRB onset.

Another phenomenon to be aware of is a somewhat common form of hair pulling that begins in early infancy and is sometimes referred to as "baby trich." This early manifestation of hair pulling is, in many cases, a more benign and self-limiting variety. However, in some cases, infant hair pulling may persist into childhood, adolescence, or adulthood. Baby trich and the treatment thereof will be discussed in more detail in Chapter 9.

Comorbid Diagnoses

Research suggests that depression and anxiety are commonly coexistent with BFRBs. These and other comorbid conditions may complicate treatment of BFRBs, and the therapist is advised to use good clinical judgment to evaluate the overall impact of comorbid features on a client's functioning. If it seems that the BFRB is secondary to other, more pressing concerns, these other matters should be addressed first. For example, when depressive symptoms are present to the extent that the client's general functioning is poor, or renders them unable to benefit from BFRB treatment, prioritizing treatment of the depression seems sensible and may facilitate successful treatment of the BFRB. If a person is picking their skin in times of stress, worry, or anxiety, then addressing those conditions in treatment is appropriate, since therapeutic progress is likely to be impeded if the anxiety is left unaddressed. Of course, there are cases where comorbid conditions are severe enough to prioritize in treatment. Decisions must be made whether these can be handled by the BFRB therapist or whether they should be referred to another professional.

Prevalence

The prevalence of HPD in adults has been estimated to be as low as 2 percent and as high as 5 percent in community and in clinical samples. However, small sample sizes, varied inclusion criteria, and other factors may account for the discrepancies (Mansueto & Rogers, 2012). For SPD, reported prevalence rates have an even wider range in various studies, but overall, an incidence of about 5 percent in the general population seems plausible (Odlaug & Grant, 2012). Because individuals with these disorders often conceal them from others, it is possible that BFRBs may be underreported in the general population. What seems certain is that BFRBs are far more common than was thought only decades ago and that prevalence rates are similar to those of OCD and anxiety disorders.

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What We Don't Know

Although we believe that BFRBs have a genetic contribution, that they probably affect more women than men, and that these conditions seem to affect up to 5 percent of the population, the truth is that there is a great deal of uncertainty about even those fundamental points. Obviously, we still have a lot to learn about BFRBs and what causes them. We do not know if and when BFRBs with onset in infancy and young childhood are precursors to the disorder that presents in adolescence or adulthood, or if it is a different disorder entirely. We do not know the biochemical underpinnings of BFRBs or of any pharmacological agents that reliably help people who struggle with them. We do not know the relationship that BFRBs have to other psychiatric disorders, or even if there is a relationship. We do not know what specific neurological pathways are involved in BFRBs. These and others are important questions that remain largely unanswered and therefore warrant further research efforts, many of which are underway. Rather than be dismayed by this state of affairs, however, it is useful to consider that the scientific investigation of BFRBs is relatively new when compared with most other recognized psychological disorders, and that what we have learned about them in the past three decades has provided us with a solid foundation for helping those who suffer their effects.

Next, we will turn to the impact of these disorders on people who experience them, as reminders of the unique experiences of people with BFRBs and the emotional and interpersonal tolls taken by SPD and HPD.

How Do Body-Focused Repetitive Behaviors Begin?

Body-focused repetitive behaviors typically begin in adolescence and often they first appear in seemingly benign circumstances that can set off a potentially lifelong problem. Most individuals report that they accidentally "discovered" the effects of BFRB activities during unremarkable moments, perhaps when their fingers explored their hair or skin. For some, it can seem as if ordinary grooming of hair and skin went terribly awry. For many teenagers, squeezing pimples is virtually a rite of passage, but among a minority of these, squeezing and picking at blemishes becomes SPD.

Yet BFRBs can begin in a multitude of other ways as well. One adult client who pulled out her eyelashes reported that, as a child, she had heard that wishes will come true if you pull out an eyelash while making the wish. She quickly realized that it didn't work in the way she hoped it would, but the "special feeling" she experienced at that first pull led her to continue the practice for over a decade. Another client's HPD started when she pulled a hair from her scalp to view under a microscope for a high-school biology class. These behaviors likely persisted because of a constitutional vulnerability interacting with some form of positive feedback experienced by these individuals as a result of their behavior, usually the experience of a pleasurable sensation or emotion or the reduction of a negative sensation or emotion. In other cases, clients with BFRBs reported that they either observed someone else pulling or picking or heard that others did those things. They became curious and tried it themselves. Unfortunately, over time those activities became uncontrollable. It is clear that there is a great deal of heterogeneity in the experiences associated with skin picking and hair pulling. The varied motives served by BFRB practices will be explored more fully in the next chapter. Regardless of the origin of the disorder for any individual, BFRB practices can become so interwoven with the fabric of their lives that they feel as natural, automatic, and as pervasive as moving one's body.

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What Are the Secondary Emotional and Interpersonal Effects of Body-Focused Repetitive Behaviors?

Listening to clients' experiences provides an opportunity to understand the deep hurt that can be an integral part of life with a BFRB, whether as an adult or as a young person who bears this burden. Consistently, clients report experiencing a life marred by shame, embarrassment, and isolation. In addition, many report negative impacts on educational or career pursuits, while others report family conflict and other interpersonal problems stemming from their BFRB (Woods et al., 2006). Diagnostic criteria for SPD and HPD do not include these nearly universal emotional and interpersonal sequelae of BFRBs, but comprehensive treatment cannot ignore those factors and will need to address them to some degree with sensitivity and compassion.

In the process of getting to know a client, it is important to understand and assess the emotional and interpersonal experiences of that client as related to their BFRB. More so than many other psychological and behavioral disorders, BFRBs can carry a profound amount of shame as well as a history of social rejection, teasing, or interpersonal isolation. Shame arises not only from the assumptions made because of their self-inflicted nature but also because the results are often physically damaging and potentially observable to others. This combination of ingredients can take huge personal and interpersonal tolls on the individual. Self-imposed social isolation or avoidance of ordinary experiences and relationships is common for people who wish to hide their BFRB from others, sometimes even from those closest to them. Clients often fear that they will be judged harshly for their behavior, and some may have actually experienced such reactions from others. In severe cases, clients may choose to avoid many social opportunities and intimate relationships to keep their secret safely hidden (Stemberger et al., 2000). This is further illustrated in "Emily's Story" where the physical damage of hair pulling and skin picking led to emotional and interpersonal difficulties that further complicated her life. For Emily to prevail over her disorders, she would have to come to terms not only with her behaviors but also with her own emotions and response to relationships, both of which were significantly impacted, furthering the damage to her wellbeing.

When such associated problems are present, care should be taken to address them during the course of treatment in an effort to help the client move toward a healthier self-acceptance. Some of this will occur naturally through the psychoeducation process, where the client learns that their behavior is not uncommon and that symptoms can be viewed as adaptive in that they serve some personal need, rather than seeing them as simply bizarre, weird, or disgusting practices. When a therapist assumes a casual and nonjudgmental demeanor during frank exchanges about hair pulling or skin picking, this provides clients with opportunities to disclose therapeutically useful information while concurrently working through their shame and embarrassment. It is particularly important that the therapist not show even subtle signs of surprise, disapproval, or disgust in response to any client disclosure about hair pulling or skin picking, even when it may violate common sensitivities or conventional social norms, as clients will be sensitive to any such reactions. Self-disclosure to a compassionate therapist about hair pulling or skin picking can reduce the individual's sense of shame, will encourage them to continue to disclose relevant information, and will provide useful validation and social support.

The process of addressing the shame that may exist within the BFRB client begins as early as the initial intake session, when information about the problem is shared. Discussing

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all aspects of the BFRB helps to normalize a person's experience. For example, when interviewing a client with HPD, it is important not only to ask from what body parts they pull but also to inquire specifically about pubic hair pulling as well as hair ingestion. As stated earlier in this chapter, many with HPD are embarrassed to admit to pulling out pubic hair and, without gentle but matter-of-fact inquiry, are not likely to volunteer this information. The process of routinely asking these questions and discussing the topics in a frank manner can make those behaviors seem less strange and embarrassing. Another sensitive area of questioning that is essential to inquire about is the ingestion of hair, because that practice can result in serious medical consequences, including stomach or intestinal blockage by trichobezoars ("hairballs"). In rare cases these can be fatal, so therapists must determine whether the client ingests hair in any amount, and to what degree. If there is suspicion of significant amounts of hair ingestion, especially if there are indications of gastrointestinal symptoms like excessive gas, bloating, stomach pain, hair in the stool, or, in the case of children, failure to thrive, the individual should be immediately referred for a medical evaluation.

Why Do People Engage in Body-Focused Repetitive Behaviors?

Understanding why a person engages in a BFRB is fundamental for effective treatment. The short answer though is simple, because it feels right to do it. It is important to explain to clients that they are engaging in the BFRB because it helps them in some way to get a need, or a number of needs, met – in other words, it is an *adaptive practice, albeit a faulty one*. The job of the therapist is to determine how it is adaptive for each person, then to help identify other, healthier or less damaging ways to get those needs met. Depathologizing BFRBs can be helpful, especially when working with family members or significant others who may not understand why a person would engage in such practices. It is useful to explain that we all engage in behaviors at times that are not good for us, even when we are aware that we are engaging in them. For example, people might be aware that they are eating a certain food that is not a "great choice" for them (e.g., a hamburger and French fries, chocolate cake, potato chips), especially if they are trying to eat healthfully – but they eat it anyway. We have all made poor food choices, sometimes repeatedly, because in that moment, the moment when considering food options, we choose what we *want, not what's best for us*, because prior experiences lead us to believe that it will satisfy us to do so. Using common examples such as healthy eating or TV watching versus getting some quality exercise emphasizes that failures of self-control often involve choosing to engage in activities that have more immediate desirable outcomes, though they can have negative impacts in the longer run on our personal wellbeing. Exchanges such as these can help clients to feel more normal and validated for engaging in what they may have believed to be weird and incomprehensible behavior.

Clinical Presentation for Hair Pulling Disorder

The most common clinical presentation is that of a female, with the onset around puberty, who pulls from her scalp, eyelashes, or eyebrows, and possibly other sites as well. Among adults, the gender ratio for clients is thought to be about nine to one in favor of women. However, some evidence suggests that this disparity may be an artifact of self-selection. It is possible that the higher prevalence rate of women is due to a greater proportion of women seeking treatment for this problem than men (Grant et al., 2021). It is also possible that men

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who pull hair from their beard or mustache may simply shave off their facial hair when the damage becomes too noticeable.

Hair loss as a result of trichotillomania can vary from largely undetectable to thinned out, patchy with irregular bald spots, or totally denuded scalp, eyelashes, or eyebrows. Typically, people with HPD are masterful at camouflage and their hair loss may be imperceptible due to the use of wigs, makeup, hair pieces, or head coverings. It is important to talk to the client about the extent of their hair loss, as well as their efforts to mask the hair loss which, in itself, can be costly and time consuming – other potentially significant negative consequences of HPD. The therapist should not assume that because hair loss seems minimal or is not noticeable that the pulling does not cause the client significant distress. Some individuals are greatly distressed by relatively mild HPD, while others may be less bothered by much more significant hair loss.

Questions arise as to whether or not clients should be encouraged to show their therapist some or all of the physical damage that exists. This probably should be decided on a case-by-case basis since individual sensitivities, timing, and the quality of the client–therapist relationship will vary and should be considered. It can be helpful to ask the client if they would like to show the area(s) from which they pull (when appropriate), with the caveat that it is perfectly OK if they do not. The same consideration should be given to other clinical recommendations such as whether or not to have the client save hairs they have pulled to be viewed or counted by their therapist. Again, this is certainly not a necessary part of treatment and clients will mostly resist doing this. The Self-Monitoring Form that will be introduced in Chapter 3 includes a hair count for each hair pulling episode and works quite well, removing the need for the client to save the pulled hairs.

Clinical Presentation of Skin Picking Disorder

As with HPD, SPD typically begins in early adolescence; however, the male-to-female ratio seems to be about equal (Odlaug & Grant, 2012). When skin picking begins during adolescence, acne is often the trigger. Cases that begin at earlier ages typically involve nail biting or picking, mosquito bite scratching, scab removal, and combinations of these activities. Skin picking can occur on any part of the body, and it is helpful to ask fairly detailed questions about the specific areas of the body that are targeted and the type of picking that occurs there. For example, a person may pick on the face and back for acne, but they may also pick from the bottoms of their feet when blisters or callouses are present. Although both of these behaviors are classified as skin picking, they potentially have different motivational and reinforcing factors. Thus, they may warrant somewhat different intervention approaches. It is important to ask about medical consequences of picking, such as infections, scarring, and other tissue damage, to help gauge the severity of the behavior and to identify any potential medical issues that may require attention. Sometimes people present with obvious scars and observable, newly excoriated areas, while other times picked areas are concealed with makeup or clothing. Again, it is important to inquire beyond visible damage because it is possible that significant damage might be hidden from view. As with hair pulling, it is important to talk to the client about the time, effort, and money spent not only on their skin picking but also that which is devoted to repair or concealment of resulting damage. These too can be significant personal tolls of skin picking. The impact of BFRBs on family and social functioning should not be underestimated and should be explored. In cases where family functioning is seen as contributory to BFRB problems,

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the therapist may choose to include interactions with family members where it seems appropriate to do so.

Correcting Client Misinformation

Clients almost always present for treatment with misinformation derived from sources such as the Internet, or from poorly informed family members, friends, or even mental health professionals. Early in the therapeutic process, it is helpful to dispel any misinformation that a client received regarding hair pulling or skin picking. Here are some common misconceptions (myths) that many clients (and therapists as well) often have that should be challenged and clarified.

Myth 1: Body-Focused Repetitive Behaviors Are the Result of Childhood Sexual Abuse or Other Trauma

One common misconception is that BFRBs are the result of prior childhood sexual abuse (*Washington Post*, 2021). This belief is probably based on some early speculation in the professional literature in the absence of reliable data. In reality, there is little to suggest that individuals with BFRBs have experienced any more childhood sexual abuse than that found in the general population (Lochner et al., 2002). Furthermore, only about half of people with a BFRB report any notable life stressors occurring prior to or concurrent with symptom onset. When such stressors are reported, they tend to be events such as parental divorce, the death of a grandparent, or changing schools. There is little evidence that traumatic events consistently preceded or were notably causative in the onset of these disorders. In fact, therapists who invest therapeutic time and energy in search of such origins of BFRBs will come up empty in the vast majority of cases. Furthermore, misguided efforts to uncover nonexistent trauma may squander valuable therapy time and undermine client confidence in treatment. Therapy for BFRBs remains the same whether trauma was present or not, although if trauma is a primary presenting problem or is uncovered during routine interview, these issues warrant proper attention. Consideration might be given to addressing the trauma before beginning work on the BFRB.

Myth 2: Body-Focused Repetitive Behaviors Are the Result of Some Underlying Issue That Needs to Be Resolved, Because Once the "Root Cause" of the Hair Pulling or Skin Picking Is Uncovered, the Behavior Will Disappear

This misconception is, in part, born out of psychodynamic perspectives and will likely lead clients and mental health providers down therapeutic pathways that end in frustration and treatment failure. When therapy for BFRBs is focused on "underlying issues," even when such issues are identified and resolved, the BFRB will likely remain intact. While we believe that addressing underlying issues in therapy can be important for many clients, it would be a mistake to focus BFRB treatment on these issues with the assumption that resolution of them will lead to reduction of hair pulling or skin picking. BFRBs are best thought of as self-sustaining behavior patterns that are strengthened and perpetuated by currently operating variables, even when their originating factors no longer exist. As you will see in the following chapter, BFRBs are maintained and strengthened by multiple elements that can be

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independent of causative factors. Put simply, there is no compelling empirical basis to support the view that therapy focused on gaining insight into otherwise unresolved, underlying dynamic issues has any efficacy for helping to mitigate BFRBs (Penzel, 2003).

Myth 3: Body-Focused Repetitive Behaviors Are a Form of Intentional Self-Harm or a Desire to Be Unattractive

While on the surface it may look like the systematic removal of one's hair (particularly in more severe cases) is a form of self-mutilation, or that creating lesions in one's skin is a form of self-harm along with self-inflicted cutting or burning of the skin, this is not the case. People with BFRBs pull their hair and pick their skin because it serves some needs for them, but self-damage is not the objective. It is the therapist's job to determine what needs are served and to address them by methods that do not result in damage to the body. The driving force for the BFRB is not "to destroy myself" or "to be unattractive," but to somehow "feel better." Therapists who operate from other assumptions can be seen by clients as judgmental, blaming, and negative and thus may inadvertently contribute to the client's feelings of shame and humiliation.

Myth 4: Willpower Is the Key to Success in Ending a Body-Focused Repetitive Behavior – Hair Pulling and Skin Picking Are Just Habits and Can Easily Be Changed If a Person Has the Desire and/or Willpower to Do So

Quite the contrary, BFRBs are more accurately thought of as strongly ingrained psycho-neurological disorders. They comprise a complex set of behaviors and other factors associated with a variety of triggers and reinforcing elements that encourage their continuation. Assuming that BFRBs are "simply habits" implies that they are easily changed by trying harder. Such assumptions can result in frustration for the client and for the therapist when change does not happen quickly or easily. A thorough exploration of a client's motivation and readiness for change is critical and will be discussed in Chapter 3. However, one thing is important to keep in mind with regard to this issue: Ambivalence about giving up the BFRB is the rule with very few exceptions and is *not* an indication of the individual's potential or lack of potential for change. Remember that hair pulling and skin picking can provide a wide range of satisfying experiences for clients with BFRBs. Mixed feelings about forgoing any reliable sources of satisfaction, despite their negative, longer-term consequences, is a challenge for every human being and it certainly is not unique to people with BFRBs.

This chapter has covered a lot of ground, including what BFRBs are, as well as what they are not. We provided some information about other disorders that seemingly have some overlap, but which require different approaches to treatment. We reviewed some basic information about BFRBs regarding prevalence, course, age of onset, gender differences, and also pointed out that there is a lot we still do not know and must learn. We reviewed the clinical characteristics of BFRBs and outlined comorbid disorders, as well as the personal toll that BFRBs have on those engaging in them. Finally, we reviewed some common myths and misconceptions about BFRBs to help correct any misinformation about these problems that can derail treatment. In the next chapter we will use the ComB framework to lay out the details of the complexity and heterogeneity of BFRBs in a manner that will provide easy access to the ComB treatment approach that will follow.

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