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Dermatillomania as a Mental Health Issue Among Young Adults: A Narrative Review

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ABSTRACT

Dermatillomania, also known as skin picking disorder, is a body-focused repetitive behavior associated with significant psychological and physical consequences, particularly among young adults. This narrative review aims to summarize current knowledge regarding its clinical characteristics, diagnostic approaches, prevalence, underlying triggers, and available treatment options, with a focus on its impact on mental health. A targeted literature search was conducted using PubMed and Google Scholar, including publications from 2015 to 2026.

The findings indicate that dermatillomania is relatively common yet frequently underdiagnosed, with onset typically occurring during adolescence. The disorder is strongly associated with emotional dysregulation, stress, and anxiety, and often coexists with other psychiatric conditions such as depressive and anxiety disorders. It can lead to substantial impairment in daily functioning, reduced quality of life, and social withdrawal, largely due to feelings of shame and stigma. Diagnostic assessment relies on established clinical criteria supported by validated screening tools, although challenges in recognition persist.

Therapeutic strategies emphasize a multidisciplinary approach. Psychotherapeutic interventions, particularly cognitive-behavioral therapy and habit reversal training, remain the cornerstone of treatment, while pharmacological options - such as selective serotonin reuptake inhibitors and N-acetylcysteine - may provide additional benefit. Despite available interventions, there is still no standardized treatment protocol.

In conclusion, dermatillomania represents a significant but often overlooked mental health issue requiring greater clinical awareness, improved diagnostic strategies, and further research to optimize treatment outcomes.

Objective. In this narrative review, we aim to provide an overview of dermatillomania as a clinical condition, including methods for its effective diagnosis, prevalence, treatment, and its impact on mental health among young adults.

Materials and methods. We conducted a targeted literature review using the keywords: dermatillomania, skin picking disorder, excoriation disorder, treatment, mental health. The primary data sources were PubMed, selected for its broad and comprehensive range of publications in the fields of biomedical and psychological research, and Google Scholar. We included all systematic reviews, narrative reviews, studies, and case reports from 2015 to 2026.

Keywords: dermatillomania, skin picking disorder, excoriation disorder, treatment, mental health

Introduction

Body-Focused Repetitive Behaviors (BFRB) constitute a group of mental disorders characterized by compulsive behaviors that cause self-inflicted bodily harm through recurrent pulling and picking. These include, among others, dermatillomania (skin picking), trichotillomania (hair pulling), and onychophagia (nail biting). Psychological factors such as anxiety, difficulty regulating emotions, stress, and depression play a significant role in the occurrence of these disorders [1,2]. Dermatillomania, also known as skin picking disorder (SPD), is defined as repetitive scratching, biting, or rubbing of the skin that leads to self-injury, causes the patient discomfort, and is very often associated with attempts to stop or reduce the picking. In addition to their own fingernails, individuals with SPD use tweezers, scissors, or other tools [3]. As a result of recurrent skin damage, open wounds, scabs, swelling, and infections may develop. The etiology of this disorder is not fully understood, but it is suggested that its occurrence is influenced by genetic factors, mental health conditions, and changes in brain structure [4]. Negative behaviors in patients are reinforced by reduced tension, feelings of pleasure, and satisfaction. On the other hand, they are often associated with feelings of shame and a loss of control over one's behavior. Patients are aware of their actions to varying degrees [5]. Due to diagnostic difficulties and the need for targeted therapy, it is essential for physicians to better understand SPD in order to provide patients with appropriate care. To date, no FDA-approved treatment protocol for dermatillomania has been established. It is important to emphasize the need for this group of patients to collaborate with a psychiatrist or psychologist,

given the prevalence of feelings of shame, self-stigmatization, concealment, and loneliness among them [6,7].

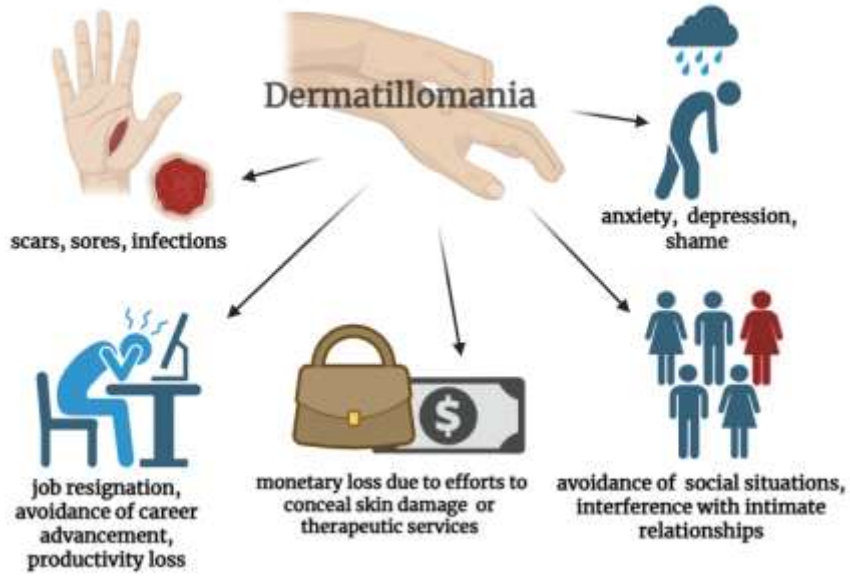

Fig. 1 Impact of SPD on areas of the patient's life: physical, psychological, occupational, financial, and social [12].

Research findings:

Diagnostic criteria

The diagnostic criteria for dermatillomania include the presence of recurrent skin picking in the patient, which causes skin lesions. They also include repeated attempts to reduce or stop the picking. Additionally, the picking causes the patient significant distress or impairment in important areas of life, such as social or occupational functioning. These behaviors must not be attributable to the effects of psychoactive substances or another mental illness or disorder. The most commonly used tools for screening patients for SPD symptoms include the Skin-Picking Scale–Revised (SPS-R), the Skin Picking Symptom Assessment Scale (SP-SAS), and the Skin-Picking Impact Scale (SPIS). However, the Diagnostic Interview for Skin Picking Problems (DISP) is the only available tool for making a diagnosis based on DSM-5 criteria [8].

Dermatillomania—how common is it and who does it affect?

The prevalence of dermatillomania is estimated at 1.4%–5.4% [9,18]. In a sample of 262 individuals, 87% of patients were women. In over 90% of the patients included in the study, the first symptoms appeared before the age of 20, and the peak age of symptom onset was 12.9 [10]. In another study involving 281 adults with BFRB, 79.4% were women, with a mean age of 29.1 years [11]. In a separate study involving 701 adult respondents, no difference in gender distribution was observed, and an analysis of the age of onset of the first symptoms identified

two groups—a smaller one (7.1% of the sample) with an average onset in adulthood (mean 42.8 years) and a larger one (92.9% of the sample) with an average onset of skin picking during adolescence (mean 13.6 years) [12].

Triggering factors

In a study conducted on 17 participants from the United Kingdom, the triggering factors for skin picking included: the desire to smooth the skin's texture, influenced by its unsuitable texture, feeling unwell and the desire to relieve frustration, boredom, periods of inactivity or waiting, nervous emotions such as stress or anxiety, and deep emotional issues related to abuse, loss, or exploitation [13]. In another study (n=262), the most common triggers were skin texture (66.9%), stress (55.2%), the sight of the skin (43.4%), boredom (38.2%), thoughts or the urge to pick (38.8%), sedentary/passive activities (35%), feelings of anxiety/worry (24.3%) [10]. Another study showed that the urge to pick in individuals with SPD can be triggered by visual cues associated with picking compared to a control group without SPD [14]. In a study sample of 546 individuals, attention was drawn to the factor of traumatic life events, which may contribute to the onset of skin picking [15]. In a study conducted by Christina Gallinat et al., approximately two-thirds of participants (n=93) confirmed that intense emotions trigger skin-picking behaviors in them. The most frequently reported emotional states were boredom (86.7%), physical tension (82.3%), and strong negative feelings (76%) [16]. Our search also included a study describing cases of dermatillomania induced by medications from the groups of selective serotonin reuptake inhibitors (SSRIs), selective norepinephrine reuptake inhibitors (SNRIs), monoamine oxidase inhibitors (MAOIs), and dopamine and norepinephrine agonists [17]. Another review identified dermatological conditions—including acne and eczema—as well as stress, anger, anxiety, a sedentary lifestyle, passive activities (reading, watching TV), boredom, and fatigue as triggers for SPD. Attention was also drawn to the fact that skin picking directly precedes looking at the affected areas or touching them and feeling an abnormal texture [18]. In another study, the listed triggers included: emotional triggers (stress, anxiety, sadness, and the like), situational triggers (lying in bed, reading, driving, being alone), perceptual triggers (noticing skin imperfections, feeling itchy), and environmental triggers (seeing one's own photo or reflection in a mirror). However, the most common triggering factors were negative emotions (anxiety, frustration) and the desire to distract oneself from them [19].

Body areas most commonly affected by skin picking

The areas most frequently selected by patients were the face (55.1%), arms (28.3%), fingers (23.2%), scalp (21%), and the torso and legs (20.3%) [10]. In a study involving 163 participants

with pathological skin picking, the majority of patients (70%) reported three or more body areas affected by picking, the most common being the face, chest, and arms (50–84.4%) [16]. Another review notes that patients often choose easily accessible areas that are frequently exposed—the face, upper back, or extensor surfaces of the limbs [18]. SPD is typically more severe in areas accessible to the patient (face, scalp, dorsal surface of the hands, forearms, upper back, buttocks); however, we should not neglect a full examination of the patient, as they may also choose areas more concealed under clothing [20].

Co-occurring mental disorders

Among the most common mental disorders associated with SPD, patients most frequently reported: trichotillomania (24.4%), generalized anxiety disorder (21.8%), depressive disorders (21.5%), and Attention Deficit Hyperactivity Disorder (ADHD) [10]. In a study involving individuals with BFRB (patients with trichotillomania and/or skin-picking disorder; n=281), 105 participants (37.4%) met the criteria for borderline personality disorder. Additionally, the co-occurrence of this disorder with BFRB was statistically significantly associated with greater severity of BFRB symptoms, a higher lifetime prevalence of suicide attempts, a higher likelihood of alcohol abuse, and the presence of compulsive buying disorder, compulsive sexual disorder, and gambling disorder ($p<0.001$) [11]. The authors of another study comparing two groups of patients—those with early-onset (during adolescence) and late-onset (adulthood; mean age of onset 42.8 years)—noted that major depression, generalized anxiety disorder, panic disorder, and post-traumatic stress disorder were more frequently comorbid in the late-onset group [12]. Mood disorders (85%) and anxiety disorders (77%) were also listed among the most common comorbid mental disorders (n=176) [20].

Impact on mental health

SPD affects various aspects of a patient's life, both physical and mental. Excessive skin picking often leads to bleeding, scarring, and infection. Patients often use appropriate clothing or makeup to conceal the damaged skin. After an episode of skin picking, patients report feelings of shame, hopelessness, as well as fear and humiliation. Additionally, they feel uncertain about professionals' knowledge of SPD, which often hinders diagnosis and treatment [13]. In a study involving 163 participants suffering from pathological skin picking (PSP), patients were asked about the emotions they experienced following a PSP episode. As many as 122 respondents (77.2%) felt anger, 112 (70.9%), self-anger—110 people (69.6%), and guilt—108 (68.4%). A strong negative correlation was also demonstrated between the severity of skin picking and self-

esteem as well as self-perceived appearance ($p<0.001$) [16]. Regarding psychosocial consequences, feelings of social embarrassment, reduced productivity, and avoidance of activities or situations where skin lesions might become visible were reported [18]. Furthermore, these disorders are associated with reduced quality of life and a higher suicide rate. Among individuals with SPD, dropping out of school or work, or permanently discontinuing education due to symptoms, is more frequently reported [20]. This disorder is associated with social withdrawal—staying at home, canceling dates [21]. In a study involving 170 participants with skin-picking disorder, their sleep-related complaints were assessed in comparison with a control group without these disorders. Compared to the general population, individuals with SPD showed higher rates of sleep apnea, restless legs syndrome, narcolepsy, and symptoms of affective disorders [22].

Pharmacological treatment

Pharmacotherapy can be used to treat SPD, but it is important to combine it with psychotherapy. Among the medications used to treat SPD are doxepin, particularly in patients with comorbid depression and/or anxiety disorders. Another group of medications that forms the basis of pharmacotherapy for SPD are SSRIs—particularly fluoxetine, as well as escitalopram, citalopram, fluvoxamine, and sertraline. Adding aripiprazole to SSRI treatment may serve as adjunctive therapy. Other treatment options also include mood stabilizers (lamotrigine, lithium, carbamazepine), although there is a lack of data in the literature regarding their use. A reduction in compulsive skin-picking behavior was also achieved with the use of N-acetylcysteine (NAC) at doses of 1200–3000 mg/day [20, 26]. In a study involving 35 participants, where NAC was administered at doses of 450–1200 mg/day for 12 weeks, significant improvement in symptoms was also achieved, along with a reduction in the number and size of skin lesions [23]. In a case report of a 13-year-old boy, resolution of SPD was observed upon increasing the NAC dose to 2400 mg/day [24]. A report describing three clinical cases of women with treatment-resistant SPD demonstrated significant improvement following the use of NAC at a dose of 1200–1800 mg/day. Additionally, in one of these patients, a recurrence of symptoms was noted after discontinuing NAC and a subsequent improvement upon its reintroduction, which directly indicates a correlation between the use of N-acetylcysteine and symptom reduction [25]. In a review article on the use of second-generation antipsychotics (aripiprazole, olanzapine, quetiapine, risperidone), no strong evidence was found that the use of this class of drugs provides any benefits to patients with SPD resistant to SSRI treatment. The association of olanzapine with weight gain in patients may even exacerbate the course of the disease. A

positive treatment effect was reported in isolated case reports of treatment with aripiprazole and risperidone [26]. A randomized controlled trial suggested that fluoxetine at an average dose of 55 mg/day significantly alleviated disease symptoms compared to placebo [27].

Non-pharmacological treatment

Psychoeducation and cognitive-behavioral therapy (CBT) are used in the non-pharmacological treatment of SPD, aiming to restructure the patient's thoughts and behaviors [20]. CBT emphasizes preventing relapse by identifying preventive measures and strengthening self-efficacy [26]. Therapists work with SPD patients to identify triggers and negative thoughts in order to replace them with more realistic and adaptive beliefs [28]. Another non-pharmacological treatment for patients with SPD that yields significant benefits is Habit Reversal Training (HRT). It involves various techniques to identify triggers and progressive muscle relaxation. The main technique involves training a competing response (an alternative behavior to the negative one, e.g., clenching the hand into a fist). This training is typically conducted by a therapist [26, 29]. In addition to CBT and HRT, support groups have also proven helpful for patients [30]. A case study evaluating the use of cognitive-behavioral therapy incorporating HRT reported improvements in treatment outcomes, including psychological stress, functioning, symptoms, and the psychosocial effects of the illness [31]. Another psychotherapeutic tool used in the treatment of SPD is acceptance and commitment therapy (ACT). Its goal is to increase the patient's psychological flexibility. It involves accepting thoughts and feelings and treating them as part of the human experience. It helps patients understand that thoughts and feelings themselves do not constitute reality, but are merely products of the human mind [32]. Combining ACT with HRT is also suggested. Numerous case studies and research indicate the usefulness of such a combination in reducing the severity of skin picking [32, 33]. Incorporating this type of therapy into treatment and collaborating with psychiatrists and therapists at an early stage of the disease can significantly improve treatment outcomes when combined with traditional dermatological treatment [33]. Our search also included a randomized controlled trial describing reductions in pathological skin picking through the use of expressive writing. This involves patients describing their personal experiences as well as their current thoughts and emotions. Immediately after the writing session, patients reported a reduced urge to pick and a reduction in tension [34]. Other non-pharmacological treatment methods include transcranial magnetic stimulation and complementary therapies such as yoga, meditation, aerobic exercise, relaxation techniques,

acupuncture, hypnosis, and biofeedback [35]. Preventive measures such as wearing gloves are also sometimes used [20].

Discussion

In the above narrative review, we analyzed the prevalence of dermatillomania and the patient group most commonly affected by this condition. The prevalence of dermatillomania cited in the reviews by Rabi and Ekore et al. and Maria Novosartyan et al. ranges from 1.4% to 5.4% [9,18]. However, it should be noted that the prevalence of this disorder may be underestimated due to patients concealing skin lesions and failing to report skin picking behavior [20]. In most studies, those affected by dermatillomania were women [10, 11, 36]. In contrast, a study involving online surveys conducted by Emily J. Ricketts et al. found no difference in gender distribution [12]. It was also noted that women seek treatment significantly more often due to aesthetic concerns caused by skin lesions [1]. In most of the analyzed studies, SPD affected adolescents and young adults. In a study conducted by Ella Flagstad et al., the mean age of patients affected by pathological skin picking was 29 years [36]; in a study by Jon E. Grant et al., the majority of patients were under 20 years of age (90%) [10]. In another study, also by Jon E. Grant et al., the mean age of symptom onset was 29.1 years [11]; in a subsequent study, 92.9% of the sample consisted of patients with an average onset of skin picking during adolescence (mean age 13.6 years) [12]. Emily J. Ricketts and colleagues also identified a group with late-onset symptoms—with a mean age of 42.8 years—though this group constituted a small portion of the sample [12]. The area of the body most frequently selected by patients was the face [10, 16, 18, 20] and areas easily accessible to patients [18]; however, a full examination of the patient and a thorough inspection of all areas should not be overlooked [20]. Among comorbid mental disorders, generalized anxiety disorders are most frequently cited [10, 12, 20]. As the above narrative review shows, SPD has a significant impact on patients' lives, including their mental health. They often experience feelings of anger, shame, rage, guilt, as well as fear and humiliation [13,16]. This condition significantly contributes to a decrease in self-esteem and negative perceptions of one's own appearance [16], which can significantly disrupt the patient's self-assessment and lead to withdrawal from social life. Patients often have doubts about specialists' knowledge of this condition, which significantly hinders the establishment of an accurate diagnosis and the initiation of treatment [13]. Another problematic aspect is the lack of a specific treatment protocol for dermatillomania. A systematic review conducted by Gabriele Sani et al. emphasized that data describing pharmacological treatment for SPD and other conditions remain disappointing, and further clinical research in this area is needed [37].

A key element of a holistic approach to the patient is the concurrent combination of pharmacological treatment with psychotherapy. The foundation of dermatillomania treatment is primarily cognitive-behavioral therapy (CBT) [20]. Habit reversal training (HRT) and acceptance and commitment therapy (ACT) [26, 32]. The complex and challenging nature of SPD presents therapeutic challenges for dermatologists. Collaboration and interdisciplinary care with psychiatrists are essential to achieve appropriate solutions. Dermatologists often serve as the first point of contact for individuals with SPD, which allows them to build relationships, promote safe skin care practices, and refer patients to psychiatrists and clinical psychologists to receive appropriate behavioral and psychopharmacological therapies [33].

Conclusion

Dermatillomania is a relatively common but underdiagnosed mental disorder that most often begins during adolescence and significantly impacts the quality of life of young adults. This condition is associated with numerous psychological and social consequences and frequently co-occurs with anxiety and depressive disorders. Emotional factors, such as stress and tension, play a key role in its development. The most effective therapeutic approach is comprehensive and primarily involves psychotherapy (CBT, HRT) supported by pharmacotherapy. Due to the lack of clear treatment guidelines and diagnostic difficulties, it is essential to raise awareness about dermatillomania and to advance further research in this area.

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