Disgust, shame and the psychosocial impact of skin picking: Evidence from an online support forum

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Abstract

This paper examines the accounts of individuals who problematically pick their skin and explores their subjective experiences. One hundred problem disclosure statements were taken from posts made to a publicly accessible online skin picking support forum. These posts were systematically analysed using thematic analysis. Themes of disgust, shame and psychosocial avoidance dominated the analysis and appeared central to the experience of skin picking. Skin picking was shown to be a heterogeneous experience with a complex emotional profile. We argue that disgust, shame and related avoidance behaviour should be considered when conceptualising skin picking and considering treatment interventions.

Keywords: Appearance; Experience; Mental illness; Psychological distress; Qualitative methods

Introduction

Problematic skin picking is a complex behaviour characterised by repetitive manipulation of the skin causing tissue damage, associated with significant distress and psychosocial impairment (Tucker, Woods, Flessner, Franklin & Franklin, 2011). Researchers have struggled to clearly define and categorise skin picking. Studies that have examined skin picking alongside substance use have suggested categorisation as a behavioural addiction (Odlaug & Grant, 2010), others consider phenomenological links with body dysmorphic disorder (Grant, Mernard & Phillips, 2006), while

elsewhere the behaviour has been referred to as 'sub-clinical self-harm' (Croyle & Waltz, 2007). Skin picking is understood to share phenomenology, triggers, consequences and functionality features with trichotillomania (hair pulling disorder; Bohne, Keuthen & Wilhelm, 2005; Lochner, Simeon, Niehaus & Stein, 2002) *and* has clinical similarities with obsessive-compulsive disorder (OCD; Grant, Odlaug & Won Kim, 2010). In 2013, skin picking was included in the fifth edition of the Diagnostics and Statistic Manual of Mental Disorders (DSM-5) as 'Excoriation (Skin-Picking) Disorder', alongside trichotillomania, within a chapter titled 'Obsessive-Compulsive and Related Disorders' (American Psychiatric Association, 2013). This diagnosis requires that skin picking is recurrent, difficult to stop, causes distress or impairment and is not explained as a symptom of another mental disorder. Many clinicians have expressed hope that the inclusion of skin picking as a discreet disorder would allow further study and ultimately improve clinical diagnosis and intervention (Stein, Grant, Franklin, Keuthen, Lochner et al., 2010), and draw attention to the clinical distress and impairment often suffered (Nemeroff, Weinberger, Rutter, MacMillan, Bryant et al., 2013). There has been criticism that this medicalises normal living and that DSM categorisation is sometimes based on opinion rather than empirical evidence (Pearce, 2014), and concerns expressed around the interests of the pharmaceutical industry and influence of DSM-5 panel members (Cosgrove & Krimsky, 2012). Broader ethical arguments voice concern that reliance on consensus-based diagnostic lists and scales risk abstraction from the patient experience and a loss of individual narrative and context (Pearce, 2014). Further research is required to critically explore DSM-5's classification and organisation of skin picking (Van Ameringen, Patterson & Simpson, 2014).

With regard to prevalence, US research by Keuthen, Koran, Aboujaoude, Large and Serpe (2010) found that problematic levels of skin picking occurred in 1.4% of a randomised sample of 2513 people, although a prevalence of up to 5.4% has been reported in non-clinical US samples (Hayes,

Storch & Berlanga, 2009). Determining prevalence rates is complicated by the fact that a low level of skin picking appears to be 'normal' and most people pick in a 'sub-pathological' manner (Keuthen, Deckersbach, Wilhelm, Hale, Fraim et al., 2000). Skin picking appears to be more common amongst women (Hayes et al., 2009; Tucker et al., 2011) and has been shown to have comorbidity with depression, anxiety, trichotillomania, substance use and OCD (Arnold et al., 1998; Lovato et al. 2012; Odlaug & Grant, 2008; Odlaug & Grant, 2011).

Research has identified notable physical and psychosocial impact and impairment as a result of skin picking. Physical bodily damage may include infection, bleeding and injuries (Neziroglu, Rabinowitz, Breytman & Jacofsky, 2008), as well as lasting tissue damage and pitted scarring(Wilhelm, Keuthen, Deckersbach, Engelhard, Forker et al., 1999). Infected sores may require antibiotic treatment (Odlaug & Grant, 2008) or surgery (Neziroglu et al., 2008). Social withdrawal and experiential avoidance are common results of picking (Keuthen et al., 2001); many sufferers evade social and public events, causing disruption to employment (Flessner & Woods, 2006; Tucker et al., 2011), and seek to conceal skin damage (Flessner & Woods, 2006). Skin picking symptoms cause significant psychological distress, including elevated rates of suicidal ideation (Arnold et al., 1998). Research suggests a relationship between psychsocial dysfunction and symptom severity, speculating a causal relationship (Grant, Redden, Leppink, Odlaug & Chamberlain, 2016).

The context and phenomenology of skin picking appears heterogeneous. Evidence suggests that the majority of problematic skin pickers pick multiple bodily sites, most commonly the face, arms, scalp and legs (Arnold et al., 1998; Tucker et al., 2011). Skin picking is sometimes triggered by roughness, scabs and bumps on the skin's surface and many pick in an attempt to improve the appearance of the skin (Bohne, Wilhelm, Keuthen, Baer & Jenike, 2002). However, a high proportion of picking is reported to occur automatically and without conscious thought or awareness (Arnold et al., 1998;

Walther, Flessner, Conelea & Woods, 2009),. Furthermore, picking is sometimes preceded by a negative emotional state, such as anxiety, tension or boredom (Keuthen et al., 2010). In one study, a majority of participants reported skin sensations such as itching, tingling or dryness prior to picking or leading to secondary excoriation (Arnold et al., 1998). Research suggests that the act of picking may sometimes induce a trance-like mental state and provide short-lived pleasure, satisfaction and relief (Snorrason, Smari & Olafsson, 2010; Tucker et al., 2011;).

Discussion of shame within skin picking research is preliminary and has so far been anecdotal. It has been reported that patterns of shame often follow picking episodes amongst a clinical sample (Keuthen, 2000) and self-reported shame correlates strongly with negative psychosocial impact of skin picking (Keuthen, Deckersbach, Wilhelm, Engelhard, Forker et al., 2001). Snorrason, Smari and Olafsson (2010) found that picking was followed by marginal increases in guilt and significant increases in shame, with similarities to emotional regulation in trichotillomania (e.g., Diefenbach, Tolin, Meunier & Worhunsky, 2008). A recent review of research on shame in obsessive-compulsive related disorders (Weingarden & Renshaw, 2015) considered skin picking alongside trichotillomania because of the limited and insufficient research into picking. The authors suggested that symptom-based shame and body shame appeared elevated among clinical samples of the two disorders, and indicated similar patterns of secrecy and avoidance in both conditions.

Skin picking is grossly under-recognised by professionals (Hayes et al., 2009). Few sufferers access help and many will wait decades before seeking treatment (Neziroglu et al., 2008; Odlaug & Grant, 2007). It has been suggested that shame and embarrassment around the self-inflicted nature of the problem may complicate recognition and treatment (Bohne et al., 2005). Tucker et al.'s (2011) study described low levels of treatment seeking, uninformed professionals and treatments with limited effect.

Given the known psychosocial impact of skin picking there is a surprisingly lack of qualitative research exploring the lived experience of people who problematically pick their skin. Research has largely been based on measures of skin picking (e.g., Keuthen et al., 2001) that by their nature cannot represent the nuances of individual voices, emotions and perspectives. It seems pertinent to attend to these voices so as to paint a more detailed picture of the range of individual experiences and needs; this is likely to add depth to clinical understandings of skin picking and thus inform appropriately heterogeneous and adaptive therapeutic interventions. Some studies have used semi-structured interviews to understand clinical features of skin picking (e.g. Arnold et al., 1998; Odlaug & Grant, 2008). However, these data have largely been analysed quantitatively and there is limited qualitative reporting on the content of those interviews.

Case studies are few in number and often focused on treatment interventions (e.g., Capriotti, Ely & Snorrason, 2015). Some have qualitatively illustrated picking by presenting details of cases, often considering their emotions as central to their experience. Deckersbach et al.'s (2003) case report described a woman's intense shame and guilt alongside social anxiety and feelings of insecurity, prompting her to use makeup to conceal the damage caused by her picking. This would often fail to relieve her concerns about her skin's appearance, and instead contribute to a further cycle of picking behaviour. She also felt guilt and shame for her loss of control when picking. Martinson, Nangle, Boulard and Sigmon (2011) similarly described shame, guilt and embarrassment in a case study of woman with severe and frequent skin picking, who reported significant distress about her appearance and a reluctance to show others her skin. While providing valuable insight into cases, these case studies cannot describe experiences nor variation across a spectrum of individuals.

Given the complex and heterogeneous nature of skin picking it is important to foster a deeper and more nuanced understanding of the lived experience of individuals who pick their skin. This study

will seek to give insight into meaning attributed to skin picking behaviour by a range of individuals and understand the nuances of its psychosocial context and impact. Because there is a perception that current treatments are ineffective and that professionals are ill-informed (Tucker et al., 2011), seeking a fuller understanding of skin picking behaviour and contributing to increased knowledge and awareness amongst professionals is overdue. To date there have been no systematic analyses of experiential accounts of skin picking. Furthermore, very little existing literature explores patterns of shame in skin picking (Weingarden & Renshaw, 2015) despite its apparent prevalence and possible impact on treatment seeking. As such this study will seek to add detail to the conceptualisation of skin picking with a particular focus on the subjective experience of self-consciousness and shame, intending to contribute towards the development of relevant treatments, and inform strategies to increase accessibility and treatment uptake

Method

Data collection and sample

Data was gathered from an online support forum for people who pick their skin in order to offer a more naturalistic perspective on skin picking with minimal researcher influence (Braun & Clarke, 2013). Online research methods have proven useful in accessing sensitive data from hard-to-reach populations (e.g., McDermot & Roen, 2012) and the internet has been shown to be a rich source of data providing insight into conditions where shame or stigma mean that anonymity is important for the participant group (e.g., Malik & Coulson, 2008). As problematic skin picking is often viewed as a pathological over-use of a benign behaviour (Hayes et al, 2009) it was important to choose only accounts where the individual reported their picking as being problematic in their own subjective terms. One hundred ‘problem disclosure statements’ (Miller & Gergen, 1998), where individuals presented their experience of skin picking as explicitly or implicitly problematic in terms of damage

caused, psychological symptoms or impact on general functioning, were purposively sampled from . The vast majority of posts met these criteria. Posts were discounted if, for example, they did not present an individual's experience (such as posts that were conversational responses to others), the level of picking was not considered problematic or they focussed on treatments or symptom management.

One hundred posts by distinct individuals were selected, with a balance of posts taken from before and after the publication of DSM-5 in 2013. This was intended to capture perspectives before and after the shift in diagnostic perspectives in case the change impacted on individuals self-concept and the manner in which they presented their experience (73 chronological posts dated 2004 to May 2013, 27 chronological posts dated May 2013 to 2015). Progress was reviewed at 100 posts and it was decided that enough data has been gathered to 'tell a rich story' (Braun & Clarke, 2013).

Ethical considerations

Ethical approval was given by the Faculty Research Ethics Committee at the Authors' Institution. As this research did not seek informed consent it was important to ensure that data were taken from an online venue considered public (British Psychological Society [BPS], 2009). The message board chosen is easily found using search engines and is accessible without registration or password protection. The site has no conditions of use disallowing posts to be used in research and the forum's user guidance explicitly acknowledges the message board area of the site to be public.

Data were anonymised by removing names, usernames, the names of others mentioned in the data (BPS, 2007). Identifiable features such as occupation and age were replaced with similar alternatives. The name of the forum itself is deliberately not included in this report. The discussion board has a file on the website specifically designed to instruct search engines not to index it,

meaning that commonly used search engines would not locate the website if asked to search for quotations used in this analysis.

Analysis

Data were analysed using a process of inductive thematic analysis (Braun & Clarke, 2006), with a focus on broad thematic patterning across the data. Analysis was conducted from a critical-realist perspective, assuming the existence of a pursuable reality while acknowledging that representations of this reality are characterised by factors such as participants' culture, language and political interests (Ussher, 1999). The excerpts were read by the first author on selection, then re-read for familiarisation. They were initially read with no specific focus, though it was noticed that many chose to disclose an intense psychosocial impact, often mediated by emotions such as disgust and shame. Interesting features were then systematically coded with a particular (though not exclusive) focus on the experience of self-conscious emotions. These codes were then reviewed with the second author, sorted into meaningful themes and all data relating to each theme were collected together. Themes and subthemes were mapped, revised and refined to ensure a good fit with the data. Personal therapy was used throughout data collection and analysis to increase researcher reflexivity, helping to suspend presuppositions and allow a more representative description of participants' reality. Writing of the literature review was delayed until after analysis, helping to reduce the impact of researcher preconceptions (Hamill & Sinclair, 2010). Given the scarcity of qualitative data discussing the nature of picking behaviours, we begin by providing some contextual discussion of the experience of skin picking. We then report on three themes referring to self-conscious emotions and psychosocial impact: "get out of my skin", "I am shameful" and "no one must ever see".

Results

Overview of the experience of skin picking

The participants' accounts depicted skin picking as a complex and heterogeneous behaviour. Many described picking multiple sites across their bodies, often choosing to include other body focussed behaviours (for example biting nails, tweezing hairs and picking their nose) together with their skin picking, suggesting that these could be viewed as similar behaviours with common meaning. Some described site preference changing over time, often following efforts to stop picking in one area, creating a sense of hopelessness that they would 'just move on to some other body part to mutilate' [E52].

Many accounts described a connection between picking and negative affect, particularly boredom, ruminating, anxiety and stress. Stress and anxiety appeared to 'fuel' [E27] skin picking and make it 'worse' [E38, E67], creating 'peak periods' [E59] of picking behaviour. Several described a compulsive behaviour where they had little control or power over their urges or the 'need to pick' [E65], often despite strong personal conviction and promises of 'it's my last pick' [E16]. Some described their 'wandering' [E43] hands unconsciously or semi-consciously scanning their bodies for bumps and imperfections. Several excerpts describing falling into a 'trance-like state' [E67, E71] while picking.

The damage of picking was discussed in physical and psychosocial terms. Physically, the accounts disclosed tissue damage, permanent impact on the 'true shape' [E38] of their skin, infections and pain. The psychosocial impact of picking appeared to largely relate to feelings of disgust, shame and the consequent interpersonal avoidance and self-concealing behaviours.

Some accounts noted the cyclical nature of skin picking; it was commonly accepted that picking created further imperfections and that a successful break from picking could improve the skin.

Some accounts suggested a wider cycle incorporating the experience and impact of shame and negative affect:

> *"Horrid, vicious cycle, this… I pick and pick, the scars make me ugly. The ugliness and frustration of being out of control depress me terribly. I need comfort. So I pick. And I'm depressed." [E43]*

We now discuss the three main themes identified.

<u>Theme 1: Get out of my skin</u>

An absolute disgust for and intolerance to bumps, skin 'gunk' [E68], imperfections within the pores and on the surface of the skin was frequently evident. There appeared to be little motivation to cause the skin itself damage, rather the impact on skin appears to be unintended 'collateral damage' from removing what were perceived to be 'foreign' entities and substances. Many accounts described being unable to tolerate anything that was experienced as 'abnormal' [E39] and needing to get every last bit out with disregard for the damage done to the skin:

> *"It seems like I HAVE to get all the disgusting stuff out of my skin." [E35]*
>
> *"…I hate/love it. I love getting this SHIT out of my face […] I use tools and tweezers and razor blades to get that 'one last bit' out….. destroying my skin in the process." [E53]*

As the above extract shows, the language used to describe extracting perceived abnormalities was sometimes aggressive and the process was seen as a 'battle' [E72]. This may suggest a separateness of the self from the contents of the skin, warranting a forceful or attacking response: 'I attacked it into submission' [E68].

Some excerpts gave the sense that the imperfections may be in some way unclean. The idea that picking would remove dirt substances and make the person 'purer' [E40] seems to be echoed in accounts of individuals seemingly disinfecting their skin with strong cosmetic chemicals:

> *"…a bad part of me says that i must get anything dirty out of my body so i pick and pick!" [E32]*
>
> *"Right now my face hurts because I have doused it with glycolic acid three days in a row, benzyl peroxide and proactive cleaner. I am pretty sure it was a bad thing to do to my skin." [E40]*

Of the accounts that described picking at scabs, the disgust and compulsion to pick tended to be targeted not at the scab itself but at the possible pus [E49, below] or 'plugs' [E43] beneath them. This suggests that any interference with healing was not intentional, but motivated by a perceived need to remove other substances. The irony of this behaviour was recognised within some accounts:

> *"When it starts to scab over I pick or squeeze because there's usually some puss (yuck) […] Then the cycle: cover with makeup, more infection, more squeezing, a little healing, more picking etc. […] I ALWAYS seem to think that I can make it better." [E49]*
>
> *"I think I try too hard for perfection, and ironically […] sabotage it by squeezing away." [E55]*

Some accounts recognised a strong pleasure or satisfaction gained from picking, particularly where it was done 'just right' [E64]. Some of these fantasised about a perfect or 'rewarding zit popping experience' [E40], seeming to define perfection as a complete and almost instant extraction of the offending substance without interference with the skin: 'Instantly the bump will be gone and your skin will be perfect' [E43]. Again, this may imply that the intention is not to cause damage but rather to cleanse the skin or make it 'flat' [E81]. This pleasure sometimes carried its own disgust, with accounts seemingly ashamed of the 'disturbing' [E28] satisfaction and relief gained from picking:

> *"…I get a little rush out of [picking] […] It's a gross and sick obsession, I know, but if I don't confess my true feelings about this stuff, I won't get better." [E31]*

Feelings of disgust are apparent throughout the experience, whether focussed on imperfections, damage caused or the individual's perceived lack of self-control.

Theme 2: I am shameful

There was a general acknowledgment that skin picking was a shameful experience. This shame was shown to impact on how individuals revealed their stories; some acknowledged they found it difficult to disclose despite the anonymity of the forum. Others felt gratitude for the opportunity to safely reveal their 'deepest, darkest secret' [E9] and relief that they were not alone in the behaviour. Statements such as 'it's good to know that I'm not the only freak' [E56] and 'it helps me not to feel too crazy' [E55] suggest a sense of isolation and feeling of shame in the world beyond the forum.

Many participants expressed disgust focussed on the symptomatic process and activity of picking:

> *"…I indulge in a destructive and shameful habit of incessantly picking at my face and upper back, chest, forearms, scalp and hands. Ick! I'm grossing myself out!" [E28]*
>
> *"…I feel so embarrassed to admit that I eat my scabs and always have a hand in my hair. I am disgusted with myself." [E15]*

On a few occasions mentions of disgust appeared to focus on the individual's sense of personal accountability for the picking, and the self-inflicted process of 'destroying' [E43] themselves. One individual described their shame at being unable to stop:

> *"The worst part for me is the shame and self-hatred. Knowing intellectually that I am harming myself and not being able to stop. Consumed with thoughts about how weak I am, how pathetic, and people must think I'm really sick." [E64]*

The idea that there's something 'wrong with me' [E22] prevailed; extending from the feeling that 'I do something disgusting' to the more wholly negative view that 'I am a shameful person'. Some appeared to believe their skin picking indicated a more general, global personal insufficiency or fault, and interpreted their symptoms as being indicative that they were in some way a 'lesser person' [E10]:

> *"I'm scared that the dermotillomania is a symptom of fundamental deficits within me which are unresolvable. I'm scared that I do not have the power to stop myself." [E86]*

In some cases, these shameful feelings appeared to impact on individuals' sense of professionalism:

> *"Who would hire a teacher that looks like this… always picking at themselves… I am ashamed…" [E51]*

Several people were concerned that their picking behaviour made them a bad parent. Fears that children would be damaged were reflected in concerns around the familial nature of picking and that they might 'pass it on' [E18] to their child. Several accounts identified concerns for their children as a key motivator to stop picking:

> *"My children have seen my bloodied face and back. There are days I want to call 'Child protective Services' on myself." [E28]*
>
> *"I've just had my first child, and I want to be free of this – don't want to pass it on to her." [E18]*

Several statements indicated a frustration that picking is a childish behaviour that should have long been left behind. There seemed to be some shame in the struggle, as if a true adult would be able to stop picking:

> *"…I must be immature or behind in some way to still be struggling with skin picking." [E6]*

<u>Theme 3: No one must ever see</u>

Much of the shame described in the data appeared to stem from the notion that the damage from picking was 'so obvious' [E96] and that 'everyone is staring' [E54]. Throughout the data there was an emphasis on hiding skin picking by carefully concealing any damage and by avoiding exposing situations. This need to hide was by far the most evident psychosocial impairment and there were

many accounts of social avoidance. Hiding tended to involve complete avoidance of any interaction and refusal to leave the home:

> *"im in my third day of hiding now. ive made a serious mess of my face." [E7]*
>
> *"if it weren't for my very supportive husband […] I would starve to death because I will not and cannot go to the grocery store." [E66]*

Avoidance had a weighty impact on quality of life. Participants' frequently described cancelling plans and missing out on social occasions, with some recalling having missed significant life events. Some stayed home from work. Some described how their avoidance contributed to their sense of regret, adding to feelings that they were 'guilty and weak' [E75]:

> *"I have cancelled meetings with friends, missed work, let people down and one of my biggest regrets & shames was missing a friends funeral." [E74]*
>
> *"i now see that what should have been one of the most important times ever in my life turned into something mediocre and memory-less […] because of my low self-image, self-esteem; my high self-consciousness, self criticism, embarrassment…" [E56]*

There was some mention of avoidance and concealment within close relationships. Some felt that they needed to hide their skin or wounds from their partner while others avoided relationships altogether so as not to be exposed:

> *"I have never had a boyfriend. I am afraid that when he sees me he will be disgusted. And I have to admit, I am too." [E99]*

As well as experiential avoidance, many accounts detailed extensive and time consuming measures taken to conceal the damage caused by picking. Much of this revolved around using makeup to hide marks and deliberately wearing clothing that covered picking sites. There were mentions of avoidance of particular activities that might threaten this concealment, such as not going swimming because 'all the makeup wears off' [E64]:

> *"I have spent thousands of dollars on makeup and skincare. Worn long sleeves, jeans and boots in the middle of summer. Worn more makeup than a circus performer. Been hours late for engagements because I was picking then had to jump through all the hoops to cover it up. I have even not gone out when my apartment building had a REAL fire alarm because I was picking and didn't have enough time to slap on enough makeup and cover up my marks." [E89]*

Some noted that an inability to conceal picking damage presented a motivation to stop:

> *"...i can be quite good if i have a night out i know i'm going to when i want to wear a fairly revealing top, but i just want to stop once and for all." [E12]*

Some indicated that shame may be impacting on their recovery, as they acknowledged their reluctance to expose themselves through accessing treatment. It was not absolutely clear where this shame was focused, but there were hints that for some this may be around revealing the damage to a professional, and/or related to admitting that they need help:

> *"Just this week I've gotten to the point where I feel I need therapy, bit I'm just to ashamed to ask anyone for help." [E23]*

On the basis of the accounts analysed, Figure 1 presents perceived connections between disgust, picking, shame and avoidance, whereby the experience of shame may contribute to a cycle of skin picking.

[Insert Figure 1 about here]

Discussion

This study is the first to systematically qualitatively explore disgust and shame associated with, and the related psychosocial impact of, skin picking. The perceived anonymity and accepting community nature of the forum appeared to facilitate open discussions of skin picking with reduced fear of judgement. As such the data provided a nuanced and detailed description of the lived experience of skin picking.

The naturalistic nature of data collection meant that those involved chose the shape, content and focus of their disclosures. There appeared to be more discussion of shame, disgust and embarrassment than has been captured in previous research. Shame has previously been shown to inhibit direct disclosure within the phenomenologically similar condition of trichotillomania (TTM; Woods, Flessner, Franklin, Keuthen, Goodwin et al., 2006), so it is not surprising that some of the more painful details of skin picking's emotional experience are revealed by a more anonymous and unobtrusive style of research.

This study found a high level of disgust motivating participants' intolerance for bumps and imperfections, as well as further disgust targeted at the self and the skin after picking. This corresponds with research showing disgust to be a significant factor in the development and maintenance of contamination-based obsessive-compulsive disorder (Olatunji, Lohr, Sawchuk & Tonlin, 2007), which is particularly interesting given the contempt for dirt and substances of infection described in the present data. Further exploration and more robust evidence for the role played by disgust in skin picking would contribute to understanding of the behaviour and inform and advance models of treatment.

Previous research has indirectly and anecdotally noted the presence and importance of shame in skin picking (e.g. Keuthen et al., 2001). The current study confirmed this and offered new insight into the varied presentations of shame, offering examples of both shame about skin picking behaviours and more global shame about the body and the self. Body shame was evidenced by severe social avoidance and extensive concealment measures taken by some individuals. Shame is known to motivate avoidance and withdrawal (Tangney & Dearling, 2002) and this was true within the current sample. Future research should focus on understanding the instance and types of shame within skin picking, and whether these are universally held experiences.

Weingarden and Renshaw (2015) considered the possibility of a shame cycle within skin picking, whereby secondary body-shame as a consequence of picking may itself act as an emotional trigger for further picking. Accounts within the current study explicitly demonstrated some cyclical behaviour in line with this proposal, although avoidance and negative affect appeared to be significant mediating factors for some individuals. More research is needed to understand the mechanisms by which negative affect and possibly shame itself might increase picking behaviour. It may be that the self-critical internal voice of shame or depression increase vulnerability to disgust targeted at the self. Furthermore, negative affect reduces the resources that an individual could draw on to stop picking.

The significance of shame in skin picking has several implications for treatment. Shame is known to impact on help-seeking and is a common barrier to treatment in OCD (Garcia-Soriano, Rufer, Delsignore & Weidt, 2014). Online treatment modalities or structured self-help programmes may help individuals to engage in treatment when their shame prevents access to face-to-face therapy. Research into treatment efficacy has largely focussed on behavioural and psychopharmacological interventions (Schumer, Bartley & Bloch, 2016), which do not actively work with emotional experience. The skin picking impact cycle proposed in the current study presents different stages of picking behaviour which may help to develop more emotionally informed treatment interventions, such as work to increase disgust tolerance, to promote understanding and self-acceptance or to reduce avoidance behaviours.

A significant limitation of the current study is the lack of clinical assessment of participants. As such caution should be taken when extending the current findings to clinical populations. It is known that people who problematically pick their skin rarely seek treatment (Neziroglu, 2008; Odlaug & Grant, 2007) and it may be that those who seek online support are those who have particularly

struggled with their picking or its impact. Alternatively, there may be individuals who find their picking too shameful to disclose their experiences online. The use of an online sample also presents issues of inclusion and accessibility, representing the voices of only those with technological access and ability (Lunnay, Borlagdan, McNaughton & Ward, 2015). Further research is required to experience of skin picking in a more representative clinical sample.

This study is the first to seek to qualitatively represent the psychosocial impact of skin picking and in doing so offers many windows of insight into lives where skin picking causes clear emotional distress. It appears pertinent for future research to further explore and understand this distress so that interventions can be more attuned, accommodating, informed and responsive to client needs.

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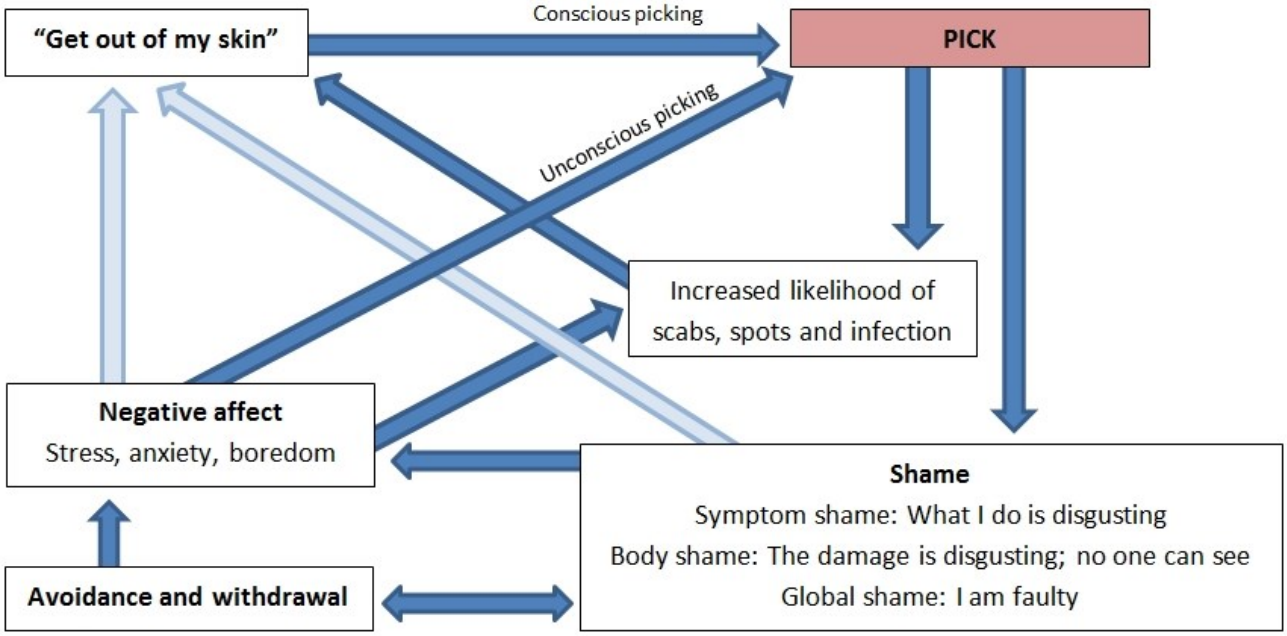
Fig. 1. Skin picking impact cycle, incorporating shame and negative affect. Connections which are not so explicitly illustrated within the data have been drawn paler.