The Problem with Picking: Permittance, Escape and Shame in Problematic Skin Picking

Suzy Anderson

A thesis submitted in partial fulfilment of the requirements of the University of the West of England, Bristol for the degree of Professional Doctorate in Counselling Psychology

Faculty of Health & Life Sciences

August 2021

This page is blank

Acknowledgements

To Those who Shared Their Stories

It has been a privilege to hear your stories. Thank you for allowing me to see these parts of you and for trusting me with your words. I hope that you feel that I have presented your stories with the respect that they deserve. I have not been able to include everything that I have been told, but I hope that you feel heard.

To Those who Supported Me

Thank you to my supervisors Victoria Clarke and Zoe Thomas; you have formidable minds. Thank you to the moderators of online picking support forums who kindly allowed me to advertise the study and who provide a safe space for people to speak freely. And an enormous thank you to my husband Tom who has helped me to organise my thoughts and to persevere despite many, many hurdles.

Contents

Thesis word count:	**36,169**
Thesis summary abstract word count:	**348**
Thesis summary word count:	**5,999**
TOTAL WORD COUNT:	**42,516**

Abstract

Problematic skin picking is a poorly understood experience characterised by a drive to repeatedly pick the skin and related psychosocial impact. Researchers have sought to understand and conceptualise this picking through noting its common characteristics, such as qualities of the drive to pick, similarities to other presentations, and its emotional context and sequelae. Qualitative research is lacking in this field, and participants' voices, insight and meanings are rarely represented. This thesis seeks to explore the lived, subjective experience of people who engage in problematic skin picking, using semi-structured interviews. Participants were given a choice of interview modality in the hope that individual needs and preferences around visibility and exposure might be accommodated. Seventeen interviews were analysed using thematic analysis. The analysis discusses the problem of picking through three overarching themes. These cover the internal 'voice' and cognitions that drove and permitted participants' picking, the phenomenology of 'zoning out' and the relief that it offered, and participants' distress relating to how they felt their picking may be seen or interpreted. Through these overarching themes, the problem of picking is presented as not just one of picking behaviour, but one of contextual emotion and of emotional and social response. This thesis demonstrates the complexity of individual picking sense-making and presents the need to understand individual formulations in order to respond with therapeutic efficacy. It contributes depth and novel ideas to the understanding of picking phenomenology and of the processes that drive and perpetuate picking behaviour. It identifies distress as a central consideration in therapeutic intervention.

Introduction

Skin picking is a common human behaviour that typically gives little cause for concern. However, for some, picking may be damaging, distressing and relate to physical, psychological and social problems (e.g. Arnold et al., 1998). The experience and conceptualisation of this more problematic skin picking (SP) has been subject to increased research attention over the past two decades. An almost entirely quantitative psychological research base has sought to delineate and define the experience of SP; definitions have formed, and treatments have been proposed accordingly. Throughout this expansion of literature little space has been given to the voices of those who pick their skin. When reading past research, I felt that the experience of SP was often abstracted from its lived context and that individual meaning was lost. I learnt little about SP as a subjective, complex phenomenology. In response to this, I analysed posts made to an online SP support forum, hoping to better capture the perspectives of those who pick (Anderson & Clarke, 2019[1]). The powerful distress and shame reported in this study revealed the need to develop knowledge of the phenomenology of SP and appropriate psychological therapies.

I have used this thesis to focus more deeply on the phenomenology of SP, using individuals' own stories and sense-making to understand the experience and problem of picking. I will present themes and patterns that underly SP and suggest inroads for therapeutic intervention. The use of qualitative methods will allow for discussion of complex experiences and their relationships, and give space to individual meanings. As those who present with SP may be cautious about disclosure and be put off by professionals not knowing about SP (Gallinat et al., 2019b), it would be helpful for therapists to have a framework in which to explore SP. This thesis will inform this framework and be useful for therapists taking an individually-focussed, formulative approach to SP distress that responds to individual meanings.

---

[1] Anderson and Clarke (2019) was written following a second-year research project that formed part of my counselling psychology doctoral programme

SP has attracted various names and definitions (see below). Throughout this research I have chosen to refer to SP in basic behavioural terms that all could relate to (‘problematic skin picking’/’SP’ and ‘picking’), whether or not they were familiar with SP’s names in research or diagnosis. I have continued with these terms in this thesis. The behavioural terms that I have chosen to use have theoretical neutrality and are in keeping with the ethos of allowing participants’ self-definition of the problematic experience of SP, rather than using terms that have inherent stipulations and assumptions about the experience (see below). All mentions of ‘SP’ relate to the problematic manifestation of the behaviour. ‘Picking’ relates to the behaviour of picking, problematic or otherwise.

Literature Review

Literature relevant to this review was identified by searching *Google Scholar*, and the electronic databases of the American Psychological Association (APA) *PsychInfo* (accessed via *EBSCO*) and the UWE library. Search terms used to identify literature specific to problematic skin picking (SP) included ‘skin picking’, ‘dermatilomania’, and ‘excoriation’. As this literature review attempts to take an expansive view of SP, considering it both within the context of broader human experience and other problematic experiences or conditions, other terms with behavioural connections to SP were searched for, such as ‘body focussed repetitive behaviour’, ‘trichotillomania’, ‘displacement behaviour’ and ‘grooming’ (see *Skin Picking’s Relationship to Other Behaviours, Conditions and Categories*), as were terms associated with related topics such as ‘appearance anxiety’ and ‘body shame’. Some studies were found more ‘organically’ by following references cited by other researchers. Where relevant scientific literature for a subject could not be found, such as for discussion of the phenomena of online dermatological acne and cyst extractions, *Google’s* search engine was used to identify relevant websites and articles published online.

Skin Picking: Definitions and Boundaries

Introducing Skin Picking

The skin is a vast and highly complex organ offering protection from and adaptation to the environment, with functions as diverse as thermoregulation, metabolism, movement and growth, and the relaying of stimuli (Montagna & Parakkal, 2012). The skin is of great psychological significance; it is a container for ourselves (Bick, 1968) and it is the point at which we connect with the world and the social forces around us (Strathern, 1975). Our skin is part of our lived selves while also being seen and touched by others, making it both object and subject (Grosz, 1994). It is an important part of identity and personal history (Egan et al., 2011; Prosser, 2001; Turner, 2012).

Attention to the surface of the body and behaviours that target and preen the skin are considered virtually ubiquitous across terrestrial vertebrates (Mooring et al., 2004). In humans, these actions may include use of the fingers and tools to pick at the skin, such as to squeeze, manipulate or scratch at the skin's surface to remove small bits. Ethological perspectives consider the self-directed behaviours of mammals to be evolved mechanisms relating to functions such as for hygiene and health purposes, social relationships, communication and tension-reduction (e.g. Aureli at al., 1999; Dunbar, 2010; Mooring et al., 2004).

Research seeking to make sense of human picking behaviour is sparse. Self-report studies of mild picking (in contrast to problematic picking) in student populations show it to be often felt to be endorsed in response to dermatological presentation, such as to improve the skin's appearance, unclog pores or relieve skin sensations (Bohne et al., 2002; Keuthen et al., 2000). Akin to tension-reduction theories in animal studies, mild human picking may be attributed to uncomfortable emotional states such as tension and nervousness (Bohne et al., 2002). Indeed, picking and scratching of the skin tends to be included alongside other body-focussed behaviours as 'displacement behaviours', referring to behaviours occurring without apparent relevance to their context, which are considered indicative of stress (Maestripieri et al., 1992; Mohiyeddini & Semple, 2013). Picking also seems to occur with limited thought and as a conditioned response; forty seven percent of Keuthen et al.'s (2000) student sample described their picking to occur "out of habit" (p. 213).

There is little reference in existing literature to the lived experience of this mild picking nor its position within human culture, though there is indication that it is hidden and considered socially undesirable. For example, behaviours included under the broader category of 'habits and addictions' are often kept secret and concealed from others (Slepian et al., 2017). Choe et al.'s (2011) paper, considering behaviours that participants wanted to be kept private, did not specifically refer to 'picking' but reported desired privacy in seemingly related acts act such as grooming, nose picking and scratching. The authors themselves labelled scratching and nose picking as "socially awkward acts" (p. 43). When considering picking across a student sample, Bohne et al.'s (2002) participants largely described picking in private and concealing picking damage, suggesting self-consciousness of picking and its consequences.

Online videos of skin picking have become phenomenally popular in recent years, with some individual videos receiving many millions of views online (e.g. ProjectKillGeorge, 2012, https://www.youtube.com/watch?v=r4zX892XOaw&feature=emb_title). Discussion of the phenomenology and appeal of this vicarious picking is limited. US dermatologist Sandra Lee, whose videos of cyst and acne extractions have at the time of writing been viewed well over two billion times (Dr. Sandra Lee (aka Dr. Pimple Popper), https://www.youtube.com/user/DrSandraLee/about), attributes their popularity to viewers experiencing “an enormous feeling of satisfaction or resolution when they watch [extractions]” and considers the videos to have “a hypnotizing quality” (Zarrell, 2015, para. 6 & 10). To my knowledge, researchers have not explored the relationship between this vicarious picking and the experience of self-directed picking, problematic or otherwise, though the above descriptions of satisfaction and hypnosis appear to echo elements of the experience of problematic SP (see below).

Defining Problematic Skin Picking

In this literature review, as I will consider academic and clinical perspectives on the nature and experience of SP, it seems vital to first understand the definitions used within (and therefore net cast by) these studies and clinicians, so as to understand who they are describing. It is possible that these definitions and selection criteria may impact the scope and focus of the picture of SP that is presented, in the sentiment of ‘the pond that you fish in determines the fish that you catch’. Likewise, the definitions used by the current study will impact those who participate and likely shape the analysis presented.

From a therapeutic perspective, self-definition of ‘problem’ may be what drives individuals to seek change and to present for therapy (though, notably, not always in instances where the individual is referred by someone else). If an individual considers themselves to be distressed by or have a problem relating to picking, yet they do not meet a therapist’s criteria for problematic SP, they still may consider themselves to have a problem with picking. Self-definition of ideas such as ‘distress’ and ‘problem’ draw from individual meaning and the complex context in which SP occurs, and are anchored in the individual’s reality. Meanwhile, reliance on other-assigned classifications may disconnect therapy from the first-hand experience that is lived by individuals and presented in therapy, and risks obscuring or neglecting individual presentation (British Psychological Society (BPS), 2013). As such, the current study will employ individuals’ self-definition; their subjective meanings and definitions will be considered useful and sufficient. Participants will be asked whether they consider their picking behaviour to be problematic and whether it in some way causes them distress (see *Appendix 2* for exact questions). These loose definitions are hoped to reflect the experience that might lead an individual to seek therapeutic support. They avoid imposition of a priori assumptions and boundaries, making the current study’s findings relevant to individuals who consider their picking to be problematic and distressing, and who may seek clinical or therapeutic help.

This use of self-definition is in contrast to the majority of literature describing SP. This section will discuss the definitions used within literature considering problematic picking as a psychopathology. It is within this field that the recent expansion in SP literature has occurred, with a view to understanding, conceptualising, categorising and treating SP as a problematic psychological condition. The discussions of SP’s characteristics are largely derived from questionnaires, scales and quantitatively analysed interviews. Qualitative perspectives are rare, and occasional case studies and vignettes (see *‘Overview of Qualitative Literature Relating to Skin Picking Phenomenology’*), while offering richer insight into individual cases, appear structured by the researchers’ interests (e.g. treatment case studies focusing on individual’s experience of therapy from the clinician’s perspective; Deckersbach et al., 2002).

SP is included as ‘excoriation disorder’ in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders [DSM-5] (American Psychological Association [APA], 2013). This inclusion has been controversial, with concerns about the impact of pharmaceutical companies

(Cosgrove & Krimsky, 2012), the questionable validity and decontextualisation of diagnostic lists, and the risk of medicalising of normal living (see Pearce's editorial discussion, 2014). It has also more recently been included in the eleventh edition of the International Statistical Classification of Diseases and Related Health Problems [ICD-11] (World Health Organisation [WHO], 2020), despite concerns about following DSM-5's diagnostic 'inflation' (Frances & Nardo, 2013). In both current manuals it is included under 'obsessive-compulsive and/or related disorders'; in ICD-11 it is further subcategorised as a 'body focused repetitive behaviour disorder' alongside 'trichotillomania' (problematic hair pulling; WHO, 2020). Inclusion in these broader categories is discussed below. Previous to these classifications, SP has been referred to throughout the literature by a variety of names, including 'dermatillomania' (e.g. Malaya et al., 2021), referencing similarities with the diagnosis of 'trichotillomania', where hair is repeatedly pulled, and 'skin picking disorder' (e.g. Schumer et al., 2016). The latter name persists in more recent research (e.g. Machado et al., 2018).

As benign picking is widespread and the act of picking is not intrinsically troublesome, problematic picking tends to be distinguished by criteria more defining of 'problematic' than of 'picking'. DSM-5 criteria specify recurrent picking resulting in lesions, repeated attempts to stop or reduce picking, and that picking causes 'clinically significant' distress or impairment in functioning in social, occupation or other important area (APA, 2013). ICD-11 criteria broadly echo these points (WHO, 2020). These criteria reflect those used in research previous to SP's diagnostic status, where SP was commonly distinguished in terms of extent of physical damage, such as 'medical problems' (Arnold et al., 2001) or 'tissue damage' (Keuthen et al., 2000, p. 211), psychological distress and/or psychosocial or functional impairment (e.g. Arnold et al., 2001; Keuthen et al., 2001a, Odlaug & Grant, 2008a & 2010). The APA's stipulation that there be repeated attempts to stop picking is not ubiquitously reflected in the literature's inclusion criteria, but echoes McGuire et al.'s (2012) criterium that it be difficult to cease or resist picking, and Arnold et al.'s (2001) view that preoccupation with the skin be "irresistible, intrusive and/or senseless" (p. 353).

A criterium divergent from DSM-5 criteria, and infrequently used, is that picking be ‘time consuming’ (e.g. Arnold et al., 2001). This stipulation is challenged by research suggesting that some individuals who pick for several hours each day do not suffer adverse impact, and thus do not meet definitions of ‘problematic’ (Keuthen et al., 2000). Some researchers have also included the emotional context and experience of picking, such as that there be feelings of tension, anxiety or agitation prior to picking, and pleasure, relief or satisfaction while picking (e.g. McGuire et al., 2012; Odlaug and Grant, 2007, 2008a & 2010). However, these emotional stipulations may be less relevant to, and therefore exclude people with, more ‘automatic’ types of picking (see Walther et al.’s (2009) distinction between ‘focussed’ and ‘automatic picking, where ‘automatic’ appears more independent of emotional context).

DSM-5 diagnostic criteria exclude picking better explained by the effects of a substance, other medical condition or another mental disorder (APA, 2013). The discussion below highlights some of the issues presented by these exclusions, not least that they appear open to interpretation and inconsistently applied. As such, the current study will not make exclusions. Medical conditions excluded are most often dermatological, such as Arnold et al.’s (1998) exclusion of individuals “with other causes of pruiritus [itching] and secondary excoriation [picking secondary to dermatological condition]”, though they do not discuss the boundaries of these categories. Odlaug and Grant (2010) mention exclusion of eczema and scabies but do not make clear whether other common conditions such as acne, keratosis pilaris or psoriasis are similarly excluded. While these dermatological exclusions seem intended to differentiate SP from picking with a more dermatological aetiology, thus having implications for treatment route, Keuthen et al. (2010) argued that dermatological exclusions may falsely dismiss those who pick disproportionately at dermatological stimuli. Problematic picking certainly seems to be relevant to dermatology patients; a recent study reported that 21.9% of participants with current skin disease symptoms (most often self-reporting acne, eczema, hives/rash and psoriasis as the primary condition) met the authors’ criteria for problematic levels of picking as assessed using the *Skin Picking Scale – Revised* (SPS-R, Snorrason et al., 2012), a scale designed to measure SP symptoms. Of those with problematic levels of picking, 60% reported consequent emotional distress and 44% reported impairment in daily life (Dixon & Snorrason, 2019). Participants were US members of *Amazon's Mechanical Turk* 'crowdsourcing' website (www.mturk.com), thus do not reflect the US or clinical dermatology populations, though are thought to be superior when compared to convenience samples such as college samples (Berinsky, 2012).

DSM-5's exclusion of SP where it may be better explained by another 'mental disorder' gives examples of picking relating to delusions, body dysmorphic disorder (BDD) (where picking may be an attempt to improve a perceived flaw), stereotypies (patterns of repetitive movements) in stereotypic movement disorder, or as deliberate intention to harm the self (APA, 2013). In literature, it is not clear whether, how or why these exclusions are applied. Some samples specifically exclude those with severe depressive symptoms (e.g. Schienle et al., 2018a; rationale not given) and picking related to voices that others cannot hear and insect or bugs on the skin (e.g. Ricketts et al., 2018; Tucker et al., 2011).

Exclusion of picking as an effect of a substance is again vaguely applied within literature, though substance use and dependence are sometimes specified as mental conditions to be excluded (e.g. Schienle et al., 2018a), with some authors more specifically excluding "cocaine and amphetamine use disorders" (Odlaug & Grant, 2010). These specific drugs are possibly named at least in part due to their ability to cause tactile hallucinations and skin sensation that precipitate picking (Hennings & Miller, 2013). I am not aware of prescribed medication use being excluded, despite suggestions in preliminary case reports that some may induce or aggravate picking, though these are limited to the observation of one or two subjects (e.g. selective serotonin reuptake inhibitors in two case reports by Denys et al., 2003; atomoxetine prescribed for ADHD in one paediatric case report by Kasar & Yurteri, 2020; the antipsychotic clozapine in one case report by Reddy et al., 2018).

In literature published since DSM-5's (APA, 2013) inclusion of SP as a distinct disorder, SP research samples have often been described as being 'based on DSM-5 diagnostic criteria', assessed by clinicians such as a psychiatrists (Oliveira et al., 2015) or clinical psychologists (Schienle, 2018a), or without details of who made the diagnostic judgement (e.g. Grant et al., 2015b). The assessor's subjective interpretation and assessment may be prone to the same issues of diagnostic stability as may be seen in clinical practice (Baca-Garcia et al., 2007); authors do not describe how the terms of the diagnosis were applied to samples nor what parameters were used for distress, impairment or excluded conditions.

Some studies instead use scales to determine their SP sample, such as Gallinat et al.'s (2019b, 2019c) use of the SPS-R (Snorrason et al., 2012) intending to limit eligibility to those with "at least mild" (Gallinat et al., 2019c, p. 2) SP. This Likert-type scale gives five-point scores for responses to eight items related to apparent elements of SP: Intensity and frequency of the urge to pick, time spent picking, control over picking, and avoidance, interference, emotional distress and skin damage due to picking. In application of the SPS-R to determine problematic levels of SP, there is variation between studies in the score chosen as cut off (e.g. seven, Gallinat et al., 2019b; nine, Solley & Turner, 2018). While Solley and Turner (2018) state that their cut-off of nine is intended to "[reflect] participants endorsing a score of 1 or above on each question, and at least one question being scored as 2" (p. 11), they do not state whether they checked that scores reflected this distribution, and scores of nine or seven could arguably be reached with scores of zero in items describing SP distress and impact, thus not necessarily reflecting all DSM-5 (APA, 2013) criteria.

Self-definition has occasionally been used within SP research. Anderson and Clarke (2019) used posts from an online SP support forum for their qualitative analysis of the experience of SP, aiming to present the perspectives of those needing and seeking out support with their picking, inferring that they themselves considered it to be a problem. It is worth noting that this self-definition would likely be influenced by popular SP discourses and information available about SP, including clinical and diagnostic perspectives, as well as the culture and focus of the forum and its members (e.g. see Mason-Schrock's (1996) discussion of the impact of forum culture on discourse). Occasional quantitative studies have allowed for self-identification, such as Grant and Chamberlain's (2020) large prevalence study where participants were included where they selected 'skin picking disorder' from a list of psychiatric conditions when asked whether they had or had ever had the conditions. However, Grant and Chamberlain's (2020) use of the clinical term 'disorder' may arguably impact whether individuals would report a problem that had not been diagnosed by a clinician.

Skin Picking's Relationship to Other Behaviours, Conditions and Categories

While SP's inclusion within DSM-5 (APA, 2013) indicates the APA's belief that SP is a distinct and singular psychopathological experience, picking is often grouped and categorised alongside other behaviours or conditions, which will be discussed below. The sparsity of SP research means that these categorisations are particularly significant within the current literature review; some studies cited will be based on assumed groupings of behaviours, and their conclusions may therefore not be illustrative of the specific experience of SP. The groupings also provide some rationale for the inclusion within this literature review of ideas from other domains seemingly related to SP; for example, discussion of the characteristics of behaviours deemed similar (such as hair pulling) may be beneficial where no information is available about SP directly. The current section of literature review will discuss how SP is categorised, boundaried and sub-divided when subject to different perspectives, and will consider how insight from the study of other behaviours and experiences may be relevant, informing a rationale for taking a broader, trans-diagnostic approach to understanding SP.

Within the study of SP as a psychopathology, SP is often grouped with other presentations, though perspectives have varied as to which characteristics are considered salient and thus define the grouping. Grouped based on behavioural similarity, SP is often considered a 'body focussed repetitive behaviour' (BFRB), a categorisation for problematic repetitive behaviours targeting the body (e.g. Teng et al., 2002; Snorrason & Woods, 2014). In this category, SP is seen as comparable to behaviours such as hair pulling and nail biting, with each involving repeated removal of small parts of the body (Snorrason et al., 2012). Research considering the relationships between SP and hair pulling have found similarities (such as in demographic variables, comorbidities and personality variables; Lochner et al., 2002), but noted differences in features such as time spent picking/pulling, behavioural triggers, and frequencies of dissociation, dysthymia and comorbid depressive disorders (Lochner et al., 2002; Odlaug & Grant, 2008b); these divergences suggest the grouping as BFRBs to not always denote similarity of experience. High rates of comorbidity between skin picking, hair pulling and nail biting (Snorrason et al., 2012) have led some researchers to go beyond this behavioural grouping to theorise that the behaviours share a common cause, such as that they may be symptom manifestations of an underlying disgust-motivated tendency towards pathological grooming, intending to foster hygiene and protect health (Maraz et al., 2017; Schienle, 2018a).

SP has also been categorised according to the nature of the drive to pick. The APA’s (2013) classification of SP as Excoriation (Skin-Picking) Disorder’ in DSM-5 categorised it alongside ‘trichotillomania’ (hair pulling) and ‘body dysmorphia’ within a chapter titled ‘Obsessive-Compulsive and Related Disorders’ (OCRD) based on shared features of obsession, preoccupation, compulsion and repetitive behaviours (Abramovitch et al., 2015). SP often overlaps with body dysmorphia’s diagnostic criteria of preoccupation with perceived flaws and repetitive behaviour focused on the perceived flaw (e.g. Phillips & Diaz, 1997) and they often co-occur (Grant et al., 2015b). The overlaps, clinical similarities and cooccurrence between SP, hair pulling and body dysmorphia have led some researchers to question whether they may be differentiated as independent conditions (Jenkins et al., 2019). The OCRD grouping also indicates relationship to obsessive compulsive disorder (OCD), though key differences have been noted; SP tends to give more pleasure and, unlike OCD presentations where there is fear of harm if the action is not completed, individuals who pick their skin tend to believe that they would benefit from withstanding the will to act (Ferrão et al., 2006). Abramowitz and Jacoby (2015) consider the OCRD grouping to be falsely based on overlapping symptoms (notably, repetitive behaviour); their critical review of the diagnostic grouping considers it to neglect significant differences between OCD and SP in terms of behaviour function, motivation, triggers, antecedents and awareness.

Prior to DSM-5's categorisation as an OCRD (APA, 2013), SP was grouped as an impulse control disorder based on the presence of excessive and harmful urges (APA, 2000). SP has been shown to fit definitions of behavioural addiction in terms of craving or urge prior to behaviour, lack of control over behaviour and continued behaviour in spite of negative consequences (definition taken from Potenza, 2006), as well as hedonic quality during behaviour (Odlaug & Grant, 2010).

SP has also been categorised according to the self-inflicted nature of the damage caused; it is sometimes included under the umbrella term of 'non-suicidal self injury' (NSSI) as it is considered deliberate injury to one's self that is not socially sanctioned, fitting behavioural definitions of NSSI (e.g. Claes & Vandereycken, 2007; Nock & Favazza, 2009). It can be shown match the diagnostic specification for NSSI in DSM-5 (APA, 2013) as it may be intended to induce a positive state and may be preceded by preoccupation. However, this definition fails to acknowledge the more subtle phenomenological differences in SP such as the intention to improve skin and that damage occurs as an unintended by-product of seeking pleasure or satisfaction (Gallinat et al., 2019a). The stipulation that picking be deliberate also excludes picking that occurs more automatically and without conscious attention (see *'Consciousness and Attention When Picking*').

The varied perspectives of SP's wider position within the study of psychopathology may reflect the significant variation in SP presentations. It is widely acknowledged that SP is a heterogenous behaviour, both within and between individuals, in terms of the nature, drive and function of picking behaviour (e.g. Arnold et al., 2001; Odlaug & Grant, 2010; Siev et al., 2012). Researchers have proposed sub-types to delineate themes between individuals, such as by distinguishing between automatic, focussed and mixed styles of attention to picking (Walther et al., 2009), and by suggesting that emotion regulation and/or addiction models may be suited to some individuals but not others (Grant et al., 2008; Pozza et al., 2016). These differences and their characteristics will be explored under '*Conceptualising the Experience of Problematic Skin Picking'*.

These sub-types of picking are trans-diagnostically related to other areas of research, such as where an emotion-regulation subtype (e.g. Pozza et al., 2016) may suggest relevance of research into distress, tolerance and abuse. The relationship between SP and emotional context has caused criticism of the decision to consider SP an independent psychopathology, as consideration of SP as an independent diagnosis assumes it to be unexplained by systemic or contextual factors, and unrelated to other human experiences (Nemeroff et al., 2013). Indeed, Stein et al. (2010) argued for SP to be considered a separate diagnosis based on several criteria, including that it is not "an expectable response to common stressors or losses or a culturally sanctioned response to a particular event" (p. 619). This appears to be in conflict with SP's commonly (though not universally) reported precursive emotional triggers (e.g. Arnold et al., 2001), theories of emotion regulation (Roberts et al., 2013; Snorrason et al., 2010), its relationship with trauma (Özten et al., 2015), and the idea that displacement behaviours (including behaviours such as scratching, fiddling, grooming and touching the face) increase with stress (Mohiyeddini & Semple, 2013; Troisi, 2002).

The idea that SP may be unrelated to other human experiences is further challenged by findings from the limited research that has considered problematic SP in parallel with more mild picking; some studies have found the two intensities of picking to share characteristics (Bohne et al., 2002; Neziroglu et al., 2008). While Keuthen et al. (2000) found differences between mild picking in a student sample and that which caused distress and impairment, such as differences in picking motivations and in emotional sequalae (higher levels of tension before picking, satisfaction on picking and shame following picking in problematic SP), others have found common ground. Bohne et al. (2002) reported on functionality, phenomenology and impact of picking across a non-clinical sample and found that participants' descriptions of mild picking echoed those of clinical samples. They found triggers to be similar, with picking intended to reduce irregularities and largely conducted in private. Unlike Keuthen et al. (2000), Bohne et al. (2002) found the emotional sequalae of mild picking to reflect that of problematic SP (participants described an increase in satisfaction and guilt after picking alongside a reduction in tension), leading them to suggest that SP may occur on a severity continuum. Neziroglu et al. (2008) correspondingly found that, when severity was measured in behavioural terms (such as by grading the frequency and intensity of picking), mild and severe picking differed only in terms of extent of distress and of physical damage. These similarities suggest that it may be problematic to consider SP to be entirely removed from mild picking. If there were a continuum, useful insight may be offered by studies of picking unconstrained by diagnostic criteria, such as the study of picking as a 'displacement behaviour' in human stress response (e.g. Mohiyeddini & Semple, 2013).

Another area typically excluded from the study of SP as a psychopathology, and specifically excluded within the DSM-5's criteria for SP (APA, 2013), is that of 'motor stereotypies'. Motor stereotypies (sometimes called 'stimming') are described as distractible patterns of repetitive, purposeless movements (Mackenzie, 2018), one of which may be picking. They are often considered to relate to 'stereotypic movement disorder' (APA, 2013) and are primarily described in the context of autism and neurological or learning disability research (e.g. Mackenzie, 2018; Singer, 2009; Sukhodolsky et al., 2008). Some researchers suggest taking a more transdiagnostic approach to stereotypies, noting similarities between SP and other simple stereotypies, such as their occurrence in response to hypo- and hyper-arousal (Stein, 2019).

Another important context for this research, which has not to my knowledge been explicitly addressed but appears relevant, is research into visible appearance and related distress. While cognitions about appearance are sometimes discussed in the aetiology of picking *behaviour*, such as that picking is intended to improve a perceived flaw, cognitions related to the experience of picking *distress* and psychosocial impact are rarely discussed. The sparse research that has considered the nature of distress and disfunction in those experiencing SP suggests that it often relates to the *appearance* of skin damage. For example, behaviours responding to picking such as the concealment of damage and the avoidance of social situations (Anderson & Clarke, 2019) appear to be used to mitigate the risk of being seen, and of skin damage being negatively appraised by others. Other areas of research that consider distress relating to appearance, such as the study of visible difference, suggest that this appearance-related distress has other mediating and contextual factors and influences, such as socio-cultural factors and psychological processes (Clarke et al., 2014). Given suggestions that distress at the visible consequences of SP may also precipitate further picking (Anderson & Clarke, 2019), the field of visible difference may offer useful insights to therapists seeking to reduce distress that both results from picking and precipitates cycles of picking.

Within this section of literature review I have highlighted several areas of research (the study of mild picking, displacement behaviours, motor stereotypies, visible appearance) that appear to have some transdiagnostic relevance to SP, though have tended not to be included within its study as a psychopathology. When considered alongside the difficulties inherent in attempting to objectively define SP (as described under *'Defining Problematic Skin Picking'*) and SP's apparent heterogeneity (as noted under '*Skin Picking's Relationship to Other Behaviours, Conditions and Categories'*), it seems that the tendency to approach SP as a singular psychopathological experience, as is inherent in its inclusion within DSM-5 (APA, 2013) as a distinct disorder, may be problematic. Narrow diagnostic groupings such as this may inhibit or mislead productive exploratory research (e.g. Craddock & Owen, 2007) and neglect insight from other domains. From a therapeutic perspective, they may also obscure individual presentation or deny individuals access to effective treatment. I hope that the current study's use of self-definition and attempts to consider picking from a more transdiagnostic perspective will allow for learning from other areas and keep individual experience at the forefront.

Prevalence of Skin Picking

Presenting statistics on the prevalence of SP is complicated by differences in SP definitions and the presence of mild picking throughout the population (Keuthen et al., 2000); when *all* levels of picking are tested for, studies report levels of picking endorsement of up to 91.7% (in a German student sample; Bohne et al., 2002). Hayes et al.'s (2009) figure of 5.4% for problematic SP prevalence in a non-clinical US community study is often cited. This figure was deduced from application of the '*Skin Picking Scale*' (SPS; Keuthen et al., 2001b), measuring picking 'severity', alongside the '*Skin Picking*

Impact Scale' (SPIS; Keuthen et al., 2001a), measuring impact in emotional and behavioural terms. Responses to their self-report questionnaires suggested that 5.4% met criteria both for significant SP and significant impact. It is interesting that this figure from the combination of scales was chosen to reflect SP prevalence given that the SPS (Keuthen et al., 2001b) alone includes items intended to represent psychosocial impact, such as distress and avoidance; the additional use of the SPIS suggests that the authors felt that the SPS did not sufficiently capture these elements of SP's diagnostic criteria. More recently, Grant and Chamberlain's (2020) study of US adults from a convenience sample showed that 2.1% self-identified as having a current 'skin picking disorder' when presented with a list of multiple psychiatric disorders and asked to identify which they had in an online survey. As previously noted, this figure may be impacted by use of the term 'disorder' and participants' interpretation of whether it applies to them, perhaps influenced by whether they had received clinical diagnosis.

SP is considered to be underreported (e.g. Tucker et al., 2011), and some sufferers of SP attribute a lack of help-seeking to feelings of embarrassment (alongside other factors such as insecurity about who to turn to; Gallinat et al., 2019b). Embarrassment is thought to impact disclosure in paediatric samples, who tend to be secretive about embarrassing behaviours to the extent that their accounts are not trusted (e.g. Storch et al., 2008). When considering hair pulling, Woods et al. (2006) found higher levels of endorsement through internet-based research than face-to-face interviews. Tucker et al. (2011) note that their more 'anonymous' internet-based methodology, comprising several online self-report scales and measures, presented different phenomenological characteristics of SP when compared to face-to-face modalities (such as higher reports of picking at pubic areas and use of tools). Researchers have reported different figures for SP when using self-report questionnaires (such as the 5.4% cited above) than when using alternative methods; the largest scale attempt to denote prevalence involved 2513 telephone interviews and found that 1.4% met the criteria suggested by DMS-5 (Keuthen et al., 2010). It seems that different research methodologies might present different pictures of prevalence, perhaps saying less about SP and more about research conditions that favour disclosure.

There tends to be female predominance in both clinical samples (e.g. Wilhelm et al., 1999) and student populations (e.g. Keuthen et al., 2000; Odlaug et al., 2013; Teng et al., 2002), though some studies on student populations have found no gender difference (Bohne et al., 2002; Prochwicz et al., 2016). It is possible that gender differences may relate to differences in emotional help-seeking (Galdas et al., 2005; Möller-Leimkühler, 2002), or differences in beauty ideals and the experience of shame where these ideals are transgressed (Magin et al., 2011). Habit disorders are reported to be less socially acceptable in men (Woods et al., 1999). It seems that both the skin's presentation and picking behaviour may have gendered differences which may impact the prevalence of SP, the reported prevalence of SP and/or the shame of SP.

Overview of Qualitative Literature Relating to Skin Picking Phenomenology

Very little published qualitative literature discusses the experience of SP. This means that the current literature review's conceptualisation of the experience of SP is largely drawn from quantitative literature. Rare qualitative perspectives will be identified as such throughout the literature review, and this section presents a brief summary of this small body of research.

Anderson and Clarke's (2019) study, previously mentioned as inspiring and revealing a need for the current thesis, considered one hundred posts made to an online SP support forum. The authors used thematic analysis focussed on participant experience to consider patterns and descriptions of self-disgust, shame and hiding, and noted the cyclical impact of these self-conscious experiences in the precipitation of further picking. Other qualitative insights into the experience of SP have been in the form of case reports, either individually or as part of a series. The majority of these have described cases, such as by noting demographics, picking location, methods, routine, triggers and consequences, and described the implementation and outcomes of particular therapies (Capriotti et al., 2015; Deckersbach et al., 2002 & 2003; Martinson et al., 2011). These experiences are reported from a combination of the clinician's and the individual's perspective, illustrated by this quotation from Martinson's (2011) case report: "She described general feelings of anxiety that often increased her urges to pick at her skin [individual's perspective]. Her frequent and severe skin picking could best be conceptualised as an impulsive, behavioural excess… [clinician's perspective]" (p. 416). Many of these case reports include occasional one or few-word quotations from the individual, such as "trance-like" and "feeling gross" to describe the experience and triggers of picking (Capriotti et al., 2015, p.236), describing participant presentations but giving limited space to participant voice. Keuthen et al. (2000) also used brief clinical vignettes with some short quotations and psychometric data to illustrate those of their sample who they considered to pick problematically, in an otherwise quantitative comparison of problematic and mild picking. While these case reports appear to involve qualitative data, they are a brief supplement to analysis of SP from a positivist perspective and the authors do not describe use of qualitative values and practices (see Braun & Clarke, 2013).

Conceptualising the Experience of Problematic Skin Picking

This section provides a summary of the experience of SP as has been presented in the literature, primarily drawing on the (largely quantitative) discussion of SP as a psychopathology. It will also include discussion of the characteristics of related or similar behaviours, such as picking behaviours that do not meet SP definitions, displacement behaviours and other BFRBs, as discussed under '*Skin Picking's Relationship to Other Behaviours, Conditions and Categories*'.

The Nature of Picking Behaviour

Research has described picking as occurring across multiple bodily sites, with the face most commonly targeted (Arnold et al, 1998; Keuthen et al., 2000; Prochwicz et al., 2016; Tucker et al., 2011). Other common sites include the arms, scalp, legs and torso (Tucker et al., 2011). Picking is often reported to occur within a daily grooming routine (Bohne et al., 2002; Deckersbach et al., 2003; Keuthen et al., 2000) and sometimes more generally throughout the day (Arnold et al., 1998). Tucker at al. (2011) found that almost all of their online SP sample self-reported using fingers and fingernails to pick (94.6%), and many also used tools such as tweezers (74.7%) and pins (49.3%) to squeeze, scratch and dig at the skin, though these rates of tool use are higher than in other studies (e.g. Arnold et al., 1998; Wilhelm et al., 1999). Reports of time spent picking vary, perhaps reflecting SP's heterogeneity and the difficulty of accurately recording a behaviour which often takes place without full awareness (Walther et al., 2009). Furthermore, picking intensity may vary over time (Wilhelm et al., 1999).

The Drive to Pick

Research shows that the drive to pick is strong enough to persist despite consequential skin damage and related distress (e.g. Arnold et al., 1998; Oliveirra et al., 2015). In their thematic analysis of online descriptions of SP, Anderson and Clarke (2019) identify participants' use of words such as "need" (p. 1777) to describe their urge to pick, and how picking continued "despite strong personal conviction and promises of 'it's my last pick'" (p. 1777). The struggle to resist picking suggests some level of compulsivity and/or impulsivity. Compulsivity is described as the avoidance of risk or negative consequence, and impulsivity relates to actions taken in spite of risk and may be pleasure-seeking (Hollander & Benzaquen, 1997). Both compulsive and impulsive characteristics have been described throughout the SP literature (e.g. through application of scales to measure impulsive and obsessive-compulsive characteristics; Hayes et al., 2009) and there may be complex overlaps between the two (Grant & Potenza, 2006).

Anderson and Clarke's (2019) thematic analysis did not directly report on impulsivity or compulsivity, but the language used by participants suggests experiences of both. Compulsivity seems evident in quotations such as "I HAVE to get all the disgusting stuff out of my skin" (p. 1777) and "I must get anything dirty out of my body so I pick and pick!" (p. 1778), suggesting picking to be driven by a want to get rid of something bad. The use of picking to alleviate uncomfortable feelings (see '*Emotional Experience and Precipitants of Picking*') may also fit the idea of compulsivity. Picking may also be the result of impulsively seeking a positive experience, such as satisfaction. A participant in Anderson and Clarke's (2019) qualitative paper described getting "a little rush out of [picking]" (p.

1778) and another said that they “hate/love it” (p. 1777), contrasting the satisfaction of picking with distress at resulting damage. The exhilaration of picking, particularly that related to the removing of substances from under the skin’s surface, seems evident in descriptions of watching cyst and pimple popping videos online, such as in Parkinson’s (2015) online newspaper article that includes the quotation that “some people just get the same sort of thrill as, say, riding on a roller-coaster” (para. 28).

Some researchers have found participants to self-report picking as sometimes triggered by the seeking of a “right feeling” sensation (quotation is of authors’ wording in a questionnaire; Neziroglu et al., 2008, p. 309). Snorrason (2016) found a relationship between ‘trait incompleteness’ and SP through use of questionnaires alongside picture-rating tasks designed to evoke and measure participants’ response to incompleteness (examples given include crooked pictures, holes in clothes and skin imperfections). Snorrason (2016) reported a sense of ‘incompleteness’ and pursuit of ‘just-right’ completeness, such as that the skin’s texture is felt to be ‘just-right’, to motivate SP. A sense of incompleteness is also thought to motivate behaviours relating to disgust (Ólafsson et al., 2020), obsessive compulsive disorder (Taylor et al., 2014) and body dysmorphia (Summers et al., 2017).

SP has been shown to relate to high measures of impulsivity (Snorrason et al., 2010). Ferrão et al. (2006) developed a scale to measure impulsive and compulsive characteristics and compared results between an OCD group and a SP/hair pulling group (of which the vast majority were diagnosed as having SP). They found significant differences between the groups, describing less “capacity to delay” (p. 284) in the SP/hair pulling group and a “short circuit” (p. 285) between will and action. More severe SP seems related to ‘delayed discounting’, where individuals prefer immediate rather than delayed rewards, perhaps explaining the preference for the immediate satisfaction of picking rather than holding out for the reward of healed skin (Murphy & Flessner, 2017).

Consciousness and Attention when Picking

Two ‘styles’ of attention during picking have been identified. In Arnold et al.’s (1998) clinical interviews with 34 adults, 24% of their participants reported being fully aware of their picking while 76% were sometimes unaware. Walther et al.’s (2009) exploratory factor analysis suggested ‘focussed’ (more intentional picking with awareness), ‘automatic’ (seemingly more habitual picking occurring outside of awareness) and ‘mixed’ subtypes of SP to differentiate these experiences, reflecting similar categorisation for hair pulling (e.g. Flessner et al., 2008b). In Anderson and Clarke’s (2019) qualitative paper, automatic picking was represented by a description of “wandering” (p. 1777) hands unconsciously or semi-consciously body scanning for perceived bumps and imperfections. Contrastingly, Deckersbach et al. (2003) included a case report of a woman who appears to illustrate a more focussed and concentrated style of picking, describing “zooming in on these spots” (participant’s words, p. 255) as part of a grooming routine in front of the mirror.

Several papers have described a degree of dissociation while picking (e.g. Gupta et al., 2017; Lochner et al., 2002). This dissociation sometimes relates to a lack of consciousness in automatic picking (e.g. Gupta et al., 2017), though there are also examples in the literature of dissociative experiences during focussed picking episodes, and a ‘trance-state’ is referenced in Walther et al.’s (2009) criteria for differentiating focussed picking. Capriotti et al.’s (2015) clinical case series considering acceptance-enhanced behaviour therapy for SP included descriptions of an individual having long episodes of “trance-like” (participant’s words, p. 236) dissociation while intentionally picking in her bathroom, an individual drifting “in and out of awareness of her behaviour” (author’s description, p. 237), and another individual who described “getting stuck” (participant’s words, p. 233) in front of the mirror and losing touch with time.

Using a self-report inventory to asses SP phenomenology, Wilhelm et al. (1999) reported that SP participants recorded feeling more intensely “mesmerized” (author’s words, p. 456) during picking (as compared to before and after picking), a word suggestive of disconnect from all else, alongside increased feelings of satisfaction while picking. The word “mesmerised” (p. 370) was also quoted as used by a woman in Deckersbach et al.’s (2002) case reports, an experience that the authors describe as releasing tension, connected to regulation of feelings such as sadness, loneliness and anxiety, though this experience is not discussed in depth. Parkinson’s (2015) online newspaper article quotes online phenomenon ‘*Dr. Pimple Popper*’ as agreeing that “there is something hypnotic about pimple popping” (Parap. 30) and describing repeatedly watching parts of her videos.

Dermatological Motivation to Pick

SP is often described as being intended to improve or correct the appearance or texture of the skin and reduce irregularities (e.g. Arnold et al., 1998; Prochwicz et al., 2016). Consequential skin damage generally appears to be collateral to these attempts to improve the skin, as articulated by a participant in Anderson and Clarke’s (2019) qualitative study: “I think I try too hard for perfection, and ironically […] sabotage it by squeezing away”.

SP is often described as having perceptual and/or tactile triggers relating to the skin (e.g. Neziroglu et al, 2008; Wilhelm et al., 1999), and onset often occurs alongside dermatological conditions such as acne (Wilhelm et al, 1999). Psychological factors relating to self-concept (such as perfectionism) have been found to be better predictors of picking for women with facial acne than the extent of the acne itself (Gupta et al., 1996), suggesting that picking is not predicted by the condition of the skin. The relevance of dermatological considerations to SP is complicated by how common conditions such as acne often do not receive medical attention nor formal diagnosis (Corey et al., 2013), so may slip through dermatological exclusions in SP’s definition. The prevalence of SP in clinical dermatological populations has been cited as low as 2% (Griesemer, 1978) and more recently as high as 21.9% (Dixon & Snorrason, 2019).

Most of Arnold et al.’s (1998) clinical SP sample, assessed using semi-structured interviews, reported pruritus (severe itching) prior to picking, though this may be impacted by the majority of participants being recruited from an outpatient dermatology practice. Where picking was independent of skin sensations it often created secondary skin sensations that prompted further picking (Arnold et al., 1998), seemingly creating an ‘itch-scratch cycle’ (Zhao et al., 2014). Teng et al.

(2002) concluded that individuals with BFRBs including picking self-report a higher awareness of bodily sensations than those without, suggesting higher attention to somatic stimuli, though the authors acknowledge that this difference in attention may be mediated by emotional or environmental factors (see ‘*Emotional Experience and Precipitants of Picking*’).

Self-Disgust and Self-Criticism in the Experience of Skin Picking

Self-disgust seems to characterise the experience of SP for many. The theme ‘get out of my skin’ in Anderson and Clarke’s (2019) paper presents a picture of disgust and intolerance for skin texture, with texture considered to be “abnormal” (p. 1777) and “dirty” (p. 1778). Schienle et al.’s (2018a) small-scale study found elevated levels of disgust and tension reported in a clinical SP sample, assessed according to DSM-5 criteria (APA, 2013), as compared to a control group, when presented with images depicting skin imperfections. Participant responses to questionnaires assessing ‘disgust proneness’ (disgust towards risk of contamination/disease) and ‘behavioural self-disgust’ (disgust towards an individual’s own behaviour) have been shown to positively relate to a more focussed style of SP, as assessed using Walther et al.’s (2009) Likert scale to differentiate focussed and automatic picking (Schienle et al., 2018b). However, the authors acknowledge that self-report measures such as this may be problematic for the assessment of more unconscious picking. This critical preoccupation with imperfections and appearance forms part of SP’s overlap with body dysmorphia (Grant et al., 2015b), a condition characterised by preoccupation with perceived deficits in appearance (APA, 2013). Similarly, perfectionism’s relationship to picking (Gupta et al., 1996) suggests picking to be driven by dissatisfaction with the skin. Perfectionism has also been implicated in hair pulling (Noble et al., 2017), BFRBs more generally (Roberts et al., 2015) and in presentations relating to obsessive compulsive disorder (Pinto et al., 2017).

Emotional Experience and Precipitants of Picking

Stress has been shown to generally increase movements focussed on the body, such as self-touching, scratching and self-grooming, in both human and animal studies (e.g. Castles et al., 1999;

Troisi, 2002). In primates, the frequency of self-directed behaviours and self-scratching is considered to sometimes be a marker of anxiety and stress (Maestripieri et al., 1992), increasing when the animal is threatened, after conflict and when restless (Aureli, 1997; Duboscq et al., 2014; Gustison et al., 2012). In humans, fidgeting is thought to reflect discomfort (Galinsky et al., 1993) and it has been theorised that its self-stimulating, sensory nature is 'self-evidencing', helping to reduce feelings of uncertainty (Perrykkad & Hohwy, 2020). 'Displacement behaviours', including scratching and face-touching, have been suggested to regulate the experience of stress in men during a social stress test, assessed through self-report, cognitive testing and monitoring of physiological response (Mohiyeddini & Semple, 2013). This has not been shown in women (Mohiyeddini et al., 2013a), a gender difference that the authors suggest may be due to the inhibiting effect of self-consciousness on women's public displacement behaviours (Mohiyeddini et al., 2013b). To my knowledge, there has been no investigation into the relationship between stress and displacement behaviours conducted in private, which would be interesting to explore given that picking is often reported to occur when the individual is alone (Bohne et al., 2002; Hansen et al., 1990; Wilhelm et al, 1999).

Given the relationship between stress and body-focussed movements it is perhaps unsurprising that research into the chronology of affect in SP has frequently found uncomfortable emotional states to precede picking episodes (e.g. Keuthen et al., 2000; Keuthen et al., 2010). Neziroglu et al. (2008) found that 98% of their SP sample from a psychiatric population self-reported using a checklist that their picking was triggered by stress and 42% by a sense of emptiness; the authors note that these statistics may be impacted by high rates of comorbidity with OCD due to sampling methods, and that the sample is restricted to individuals who have sought treatment. Research using experimental conditions has found that boredom, impatience and frustration led to higher levels of general BFRBs (Roberts et al., 2015). Prochwicz et al. (2016) similarly reported that, of those in their sample who met DSM-5 criteria for SP, 98.78% found SP to be triggered by 'daydreaming' and 97.96% by 'solving problems' and 'tension' respectively. Daydreaming and boredom are discussed in more detail under '*Environmental Factors'* based on their relationship to a lack of stimulation. Arnold et al. (1998) also found that many of their SP sample reported relatively high tension prior to picking. Grant et al. (2015a) found higher levels of self-reported stress to be related to more time spent engaging in BFRBs (though it is unclear how time was assessed) and higher impact on self-reported psychosocial functioning and quality of life (Grant et al., 2015a). There may be a gender difference in affective states associated with SP, with more women reporting emotional states such as sadness, guilt and self-aversion prior to picking (Prochwicz et al., 2016) and men experiencing higher anxiety and functional impairment (Grant & Christenson, 2007).

Traumatic experiences and stress may also play a role in SP. Research has connected a history of trauma and psychosocial stressors to childhood development of BFRBs (Kaess et al., 2013; Lochner et al., 2002; Shah & Fried, 2006). When considering traumatic experiences in relation to self-injurious behaviours, Favaro at al. (2007) found a relationship between skin picking/biting and childhood sexual abuse. In the sparse research specifically analysing SP, an association has been found between being a SP neuropsychiatry outpatient and self-reported traumatic stress, when compared to a control group (Özten et al., 2015), and SP seems significantly associated with exposure to general, sexual and psychological traumas in a large-scale Brazilian sample (Machado et al., 2018). Interestingly, Özten et al. (2015) found a reduction in post-traumatic stress symptoms with longer duration of SP or hair pulling, speculating that the behaviours may ameliorate coping. Hair pulling's relationship to trauma has also been suggested to be mediated by low mood (Houghton et al., 2016).

Picking is often reported to be followed be sensations of relief, pleasure, satisfaction or gratification (Arnold et al., 1998; Snorrason et al., 2010; Tucker et al., 2011) and a reduction in tension (Bohne et al., 2002; Wilhelm et al., 1999), similar to the emotional sequence of hair pulling (Snorrason et al., 2012). This affective dynamic has led to theories that SP may serve an emotional regulatory function, where picking helps to modulate or alleviate unpleasant emotions (Keuthen et al., 2000; Roberts et al., 2013; Snorrason et al., 2010; Wilhelm et al., 1999), as is similarly theorised in hair pulling (Diefenbach et al., 2002; Shusterman et al., 2009). Deckersbach et al.'s (2002) case reports detail the case of a man who described his picking as a means to relax and how, when his picking began in adolescence, he'd not known "how to relieve stress in any other way" (participant's words, p. 272). This experience may relate to how research considering the response to grooming in other primates has noted a reduction in heart rate and a relaxing effect, a psychological reward theorised to promote further grooming (Aureli et al., 1999; Boccia et al., 1989), and the release of endorphins and oxytocin when the skin is touched (Dunbar, 2010).

Pozza et al. (2016) found that focussed SP correlated with a lack of emotion regulation strategies (measured by self-report using the '*Difficulties in Emotion Regulation Scale'*; Gratz & Roemer, 2004), though the authors acknowledge that other experiences, such as trauma, may mediate both SP and emotional or personality traits. The correlation between SP and emotion regulation was not replicated by Schienle et al. (2018b). An emotional regulatory function has been suggested in phenomenologically similar hair pulling; Siwiec and McBride (2016) found that individuals with more focussed styles of` hair pulling reported higher levels of negative emotions before hair pulling, and their hair pulling appeared to make a marked impression on mood. Nakell (2015) presents a rare psychodynamic perspective on BFRBs, considering SP to be a self-soothing behaviour when "sufficient comfort from others isn't readily available" (p. 297), noticing how stress and isolation increase BFRBs. They observed that individuals who engage with BFRBs may use emotional resistance to cope with stressors and considered BFRBs to be a defence against the expression of unwanted feelings that might impact their "façade of perfection" (Nakell, 2015, p. 298).

Findings from other areas of research may also offer insight into the relationships between affect and SP. SP may have impulsive characteristics (e.g. Hayes et al., 2009), and impulse controls have been shown to be weakened at times of distress where short-term affect regulation tends to be prioritised over longer term goals (Tice et al., 2001). Additionally, SP seems to relate to critical thoughts about the appearance of the skin, both before and after picking (e.g. Anderson & Clarke, 2019). Low mood may increase self-criticism, particularly in those with low self-esteem (Heimpel et al., 2002), and self-criticism may in turn lower the mood (Gilbert & Procter, 2006), creating a cycle that may increase picking. There may also be dermatological relationships between affect and SP; stress may also increase targets for picking by causing inflammation and texture (e.g. Koo & Lebwohl, 2001; Senra & Woolenberg, 2014; Shenefelt, 2010) as well as impacting skin immune function and healing (Hunter et al., 2015).

Environmental Factors

Some attention has been paid to environmental factors that appear to relate to the intensity and severity of BFRBs. Under experimental conditions, children have been observed to bite their nails more when in ‘restricted environments’, such as when watching television (Woods et al., 2001. BFRBs are reported to occur more when alone (Hansen et al., 1990; Wilhelm et al, 1999), a finding which may relate to Harlow and Harlow’s (1962) ethological study which found that social deprivation increased skin picking in monkeys, though it could alternatively be the result of social environments inhibiting behaviour. In studies of human picking, Bohne et al. (2002) found picking to relate to social context in that the majority picked while alone at home, though it is not clear whether this might relate to a lack of social stimulation or that privacy is preferred. Prochwicz et al. (2016) found ‘daydreaming’ to be a picking trigger reported by 98.78% of their sample, perhaps a state relating to lack of stimulation in environmental context. Keuthen et al. (2000) similarly found that 40% of their student sample of mild pickers picked “to give themselves something to do” (p. 213).

Physical Damage

Many definitions of problematic SP require that physical damage is caused (e.g. APA, 2013). Skin damage reported ranges from mild to severe damage, including noticeable scarring, open sores, infection, bleeding, bruising, tissue damage and skin craters (Tucker et al., 2011; Wilhelm et al., 1999). Odlaug and Grant (2008a) found that a third of their SP sample had required antibiotic treatment for infected sores and some had used laser therapy or dermabrasion to reduce the visibility of scaring and ulcerations. Of their sample of thirty four, Arnold et al. (1998) reported a case where plastic surgery was required and another where damage was so severe that amputation was considered, though notably their sample was largely recruited from an outpatient dermatology practice which may impact dermatological morbidity. Elsewhere, a case report has highlighted near-fatal body damage from picking (O'Sullivan et al., 1999).

Emotional and Social Impact of Picking

Research shows that emotional distress features heavily in the aftermath of picking. Any pleasure from picking appears short-lived and picking episodes are followed by an increase in reports of shame and guilt (e.g. Keuthen et al., 2000; Snorrason et al., 2010; though notably both of these articles specify distress and/or functional impairment within their SP definition, so it may tautologically follow that these participants report higher levels of distressing and impairing emotions). Simeon et al. (1997) found that picking distress was characterised by feelings of shame, hopelessness and humiliation. Using an online survey designed to assess elements of SP phenomenology, Flessner and Woods (2006) found that 66.3% of their adult sample who engaged in "repetitive picking" (p. 947) self-reported experiencing depression as a result of picking and 85.9% said it had caused them anxiety. Arnold et al. (1998) found that 12% of their clinical sample reported suicidal ideation. The theme 'I am shameful' in Anderson and Clarke's (2019) qualitative analysis described self-disgust and shame in the act of picking. A key component of this shame appeared to centre on the inability to control their picking and a fear that this struggle reflected "fundamental deficits within me" (p. 1779). Deckersbach et al.'s (2003) case report similarly depicts a woman who described shame and guilt about her loss of control, alongside feelings of insecurity and social anxiety.

The experience of SP is often characterised by psychosocial withdrawal, sometimes to the point of being confined to the home (Arnold et al., 1998; Keuthen et al, 2001). Tucker et al. (2011) found that, of those who picked their skin to the level of 'interference', 62.5% avoided social or entertainment events and 57.7% reported avoiding going out in public. General occupational or academic interference are often reported (Flessner & Woods, 2006; Tucker et al., 2011). Simeon et al. (1997) noted the impact upon areas considered to indicate quality of life, such as leisure activities and sexual activities. In keeping with this sense of withdrawal, individuals deemed to suffer severe levels of SP (where picking had caused either significant tissue damage, marked distress or functional impairment) frequently report use of makeup (84%) and clothing (81%) to disguise SP damage (Wilhelm et al., 1999). Individuals have been reported to employ costly concealment activities to camouflage damage (Flessner & Woods, 2006) and to be concerned about picking being noticed (Wilhelm et al., 1999). This fear of exposure was illustrated in Anderson and Clarke's (2019) qualitative study, where individuals described avoiding romantic relationships, missing significant life events such as funerals, and ignoring genuine fire alarms as there was not enough time to put on makeup. This avoidance appeared to contribute to secondary distress and regret (Anderson & Clarke, 2019).

Few attempts have been made to understand the mechanisms of the emotional and social impact of picking. 'Time spent picking' seems a poor predictor of distress (Bohne et al., 2002; Keuthen et al., 2000), suggesting that distress may be mediated by factors other than the extent of the picking (though 'time spent picking' does not account for the intensity of picking). Grant et al. (2016) found that dysfunction *does* relate to SP severity, though this may be impacted by their measure of severity (a modified 'Yale-Brown Obsessive Compulsive Scale' as used in Arnold et al., 1999) including questions about functional interference and distress. Similarly, the 'Skin Picking Impact Scale' (SPIS; Keuthen et al., 2001a), a 5-point Likert-type psychometric measure intended to assess patient-rated psychosocial impact, including items such as "I feel embarrassed because of my skin picking" and "I think my social life would be better if I didn't pick my skin" (p. 400), correlates with picking severity measured by the SPS (Keuthen et al., 2001b). This is perhaps unsurprising given that psychosocial impact may also contribute to a higher SPS score; two of the eight items comprising the SPS intend to assess distress and avoidance (Keuthen et al., 2001b.

Given that SP distress often seems focussed on shame and concealment of the visible appearance of damage (Anderson & Clarke, 2019), it seems pertinent to consider the experience of those with visible difference. In the study of visible difference, the objective severity of visible difference does not appear to directly predict distress (e.g. Ong et al., 2007; Thompson & Kent, 2001). Rather distress, often called ‘appearance anxiety’, seems mediated by the individual’s subjective assessment of their appearance (Ong et al., 2007), socio-cultural factors (such as early experiences of being accepted, Kent & Thompson, 2002), psychological factors (such as psychological flexibility; Shepherd et al., 2019) and body-image disturbances (summary found in Clarke et al., 2014). The condition and presentation of the skin specifically has been shown to have a psychosocial impact, perhaps unsurprisingly in the context of societies whose beauty ideals include to be clear-skinned (Tiggemann, 2011). Skin disease increases rates of depression, anxiety and suicidal ideation (Dalgard et al., 2015), and acne in adolescent samples has been shown to relate to increased stress, distress and social impairment (Halvorsen et al., 2011). Kellett (2002) presented ‘dermatological shame’ as a form of body shame specifically “concerned with the presentation of the skin and its relative attractiveness” (p. 138).

The Relationship Between Emotion and Picking

This literature review has presented distress as both a possible consequence and precipitator of SP behaviour. Grant et al. (2016) suggest three possible explanations for the relationship; these are that picking may lead to psychosocial dysfunction which in turn contributes to distress, that the isolation inherent in psychosocial dysfunction might increase picking severity, or that distress might increase severity of picking which in turn creates psychosocial dysfunction. Qualitative literature supports these connections and suggests that multiple connections might be relevant to an individual, creating a cycle of picking, distress and psychosocial dysfunction (Anderson & Clarke, 2019). Flessner and Woods’ (2006) study of the relationship between SP severity and symptoms of anxiety and depression concluded that experiential avoidance played a part in mediating the relationship.

Notably not all researchers have connected SP to negative affect. Hajcak et al. (2006) did not find a relationship between affect and SP in their non-clinical older adolescent sample, a difference that they speculate may relate to differences between clinical and non-clinical populations or an effect to do with participant age. They wonder whether a younger sample may be more accepting of picking and thus less distressed by it, suggesting that the SP distress may be mediated by its perceived meaning, and that this meaning varied between people.

Treatment Seeking

Rates of treatment seeking for SP are low (Neziroglu et al., 2008; Tucker et al., 2011). SP is considered by those with SP to be under-recognised by medical and psychological professionals (Tucker et al., 2011), shame and embarrassment may impede recognition and treatment (Bohne et al., 2005), and treatment is often deferred for many years if not decades (Odlaug & Grant, 2007). Gallinat et al. (2019b) found that help seeking was most commonly self-reported to be inhibited by feelings that picking was not severe enough (59.5%; it is worth noting that selection criteria for this study included those with mild levels SP, as discussed under '*Defining Problematic Skin Picking'*), feeling insecure about who to turn to (46.0%), feeling that professionals would not be knowledgeable about SP (41.9%), and embarrassment (40.5%). Secrecy, concerns about cost of therapy and fear of being labelled were less commonly cited reasons (Gallinat et al., 2019b).

Specific Psychological Treatment and Interventions

Psychological and psychiatric therapies for the specific treatment of SP have largely been behavioural, cognitive behavioural and pharmacological in nature (Jagger & Sterner, 2016). Habit Reversal Therapy (HRT) (Azrin & Nunn, 1973) is a process focussed on habitual behaviours that involves increasing awareness of the habit, intercepting behaviour and learning to use competing alternative responses. It is used in the treatment of hair pulling (Elliott & Fuqua, 2000) and nail biting (Twohig et al., 2003). It has been shown to significantly reduce self-reported picking behaviours in an experimental wait-list control design, though little difference was seen when comparing photos of picking injuries at follow-up (Teng et al., 2006). Moritz et al. (2012) found that 50% of their participants reported a subjectively appraised symptom decline when receiving HRT in self-help form, though half of all participants felt that they would benefit more from the self-help in combination with face-to-face therapy.

Schuck et al. (2011) proposed that the behavioural approach of HRT may neglect the cognitive elements of SP and developed a treatment incorporating behavioural and cognitive interventions. Similar combinations of HRT and CBT have been reported to have positive effect in treatment case studies, such as Deckersbach et al.'s (2003) example of a programme of awareness and behavioural training, psychoeducation, cognitive restructuring and emotion regulation techniques. Martinson et al. (2011) similarly augmented HRT with CBT, with additional elements of exposure and relapse prevention. Schuck et al. (2011) gave examples of dysfunctional cognitions targeted by their interventions, such as that "I will not be able to relax until I have removed this irregularity" and "I cannot resist the urge" (p. 13). The authors found significant differences between those who completed the treatment condition and wait-list in terms of SP severity, psychosocial impact and dysfunctional cognitions, measured using psychometric scales SPS (Keuthen et al., 2001b) and SPIS (Keuthen et al., 2001a). This improvement was maintained at two-month follow-up (Schuck et al., 2011). The positive effects of both HRT and CBT hold up to scrutiny by Schumer et al.'s (2016) meta-analysis. Online programs based on CBT have shown promise and have the benefit of accessibility (Flessner et al., 2007; Gallinat et al, 2019c).

Acceptance and Commitment Therapy (ACT) (Hayes et al., 2011) targets behavioural rigidity that comes from experiential avoidance, seeking to instead grow acceptance of negative thoughts and feelings and to behave according to personal goals and values. Twohig et al.'s (2006) preliminary investigation of ACT as a treatment for SP, where they focused on acceptance of the urge to pick and commitment to stop picking, showed promising reduction in picking, though these effects were not maintained over time. Woods et al. (2006) developed a combined treatment of HRT and ACT hoping to better meet the needs of both 'focused' and 'automatic' hair pulling presentations (where HRT targets automatic pulling and ACT targets focused). Combinations of acceptance and behavioural therapy have been shown to be effective with SP (Flessner et al., 2008a), though this study considered just two participants experiencing SP, and was not followed up to see if the effect was maintained. A case-series using a combination of ACT and HRT (including use of stimulus control techniques such as gloves) showed marked improvement in three out of four patients measured in terms of picking severity (Capriotti et al., 2015). These decreases ranged from approximately a third to half of participants' scores on Likert-type psychometric scale SPS-R (Snorrason et al., 2012), and were accompanied by participant reports of improvement and decreases in psychosocial impairment.

A commonality of the research papers applying HRT, CBT and ACT, as discussed above, is that they largely appear to seek to reduce or extinguish picking *behaviour* with little attention given to working with the distress that *follows* picking, despite this distress and dysfunction being definitive of SP's diagnosis and forming part of what may differentiate it from milder picking behaviour (e.g. APA, 2013). Though a reduction in consequential distress or psychosocial dysfunction would be considered an improvement in SP symptomology, this distress is not given direct attention; rather it seems assumed that this distress might decrease where picking behaviour is reduced, therefore therapy targets the behaviour and the urge to pick. Where distress *is* a target of therapy, such as where emotion regulation techniques are used, the distress targeted seems to be that which *precipitates* picking and therefore contribute to the urge to pick; for example, Capriotti et al.'s (2015) series of ACT case reports included consideration for "life stressors (such as being a parent) and relationship issues" (p. 235). Similarly, Dialectical Behaviour Therapy (DBT) has been suggested to "augment HRT/stimulus control, especially when negative emotions trigger the pulling or picking" (Jones et al., 2018, p. 728), and use of DBT in hair pulling focuses on the internal states preceding the behaviour (e.g. Keuthen et al., 2011). The distress following picking, such as shame at the damage caused (Anderson & Clarke, 2019), is rarely a focus of intervention.

Psychopharmacology has received mixed reviews. Gelinas and Gagnon's (2013) meta-analysis concluded that pharmacological interventions were effective and comparable to behavioural interventions. However, a subsequent meta-analysis by Schumer et al. (2016) positions the efficacy of psychopharmacological interventions as "at best mixed" (p. 150) when considered alongside SP improvement in placebo and inactive control conditions. They attribute improvement of inactive controls to the fluctuating nature of SP intensity over time and likelihood of seeking treatment at times of particular severity. They considered the differences in conclusions between their and Schumer et al.'s meta-analyses to be due to the 2014 study's over-emphasis on uncontrolled studies (Schumer, 2016).

Rationale

Research Aims

Skin picking is a heterogenous problem associated with distress, painful self-consciousness and psychosocial avoidance. Research attempting to understand and define this experience has given preliminary insight into complicated, abstract and often unquantifiable concepts such as compulsion, attention and shame. Experiences of these concepts are not easily explained, and quantitative research methods have struggled to capture their depth and meanings. This research uses a qualitative approach, hoping to develop an expansive discussion of individual experience and sensemaking through participants' own language, explanations, comparisons, anecdotes and metaphors. Their words are organised and presented using thematic analysis, which will allow for nuance, divergence and exploration of meaning.

The current study explores the question '*what is the lived experience of problematic skin picking?*'. It intends to draw on participants' subjective experience to formulate a fuller understanding of the many experiences of picking, the relationships between these experiences and the processes by which people understand their picking problem to be defined and maintained. It is hoped that this insight will help to understand the subjective experience of picking and its distress, and therefore provide a rationale for nuanced intervention. It may help to contextualise, inform and structure the work of psychological and therapeutic professionals.

Relevance for Counselling Psychology

This study is intended to both reflect the philosophical perspective and values of counselling psychology (Strawbridge & Woolfe, 2003) and to contribute to a research base useful to counselling psychologists. In the same way that counselling psychology practice prioritises first-person accounts, promoting "the wellbeing of individuals by focusing on their subjective experience" (BPS, 2020, p. 5) so does this research intend to respect individual sense-making and discourse. My role as researcher was to facilitate the telling of these stories, in keeping with the premise within counselling psychology that knowledge may be co-constructed (BPS, 2020).

My approach was guided by Rogers' (1951) core conditions of empathy and acceptance, requiring that I listen to participants' experiences with genuine curiosity and without judgement. In application to SP, this meant attempting to put aside a priori categorisations and previous sense-making and to follow individual narratives. Listening and reporting without judgement seemed particularly important given the shame felt by many who pick their skin, and was relevant to my approach to picking as a 'problem'; I was careful to avoid the perspective that any behaviour or experience were inherently pathological, rather allowing participants to define what was problematic for themselves.

SP appears heterogeneous both between and within individuals, overlaps with other conditions and seems impacted by the contexts of people's lives. It seems imperative that therapies for those who pick their skin are not restricted by absolute definitions and unitary protocols, but rather should consider the underlying mechanisms, characteristics and contexts of individual presentations. However, there are clearly significant populations of people who identify the problem as being one of picking, and who would likely present for therapy for help with picking rather than for help with contextual or component issues. Given that those who present with SP may be cautious about disclosure (e.g. Gallinat et al., 2019b) and feel ashamed of their picking (Anderson & Clarke, 2019), it may be helpful for therapists to have an understanding of SP, both to provide a framework in which to explore SP and to offer normalising insight into the behaviour and distress. The current study hopes to provide a starting point for this understanding.

Method

Theoretical Perspective

Data were analysed using reflexive thematic analysis to identify patterns of experience and overarching themes that focus on the participants' standpoint (Braun & Clarke, 2006, 2013). Analysis was conducted from a critical-realist perspective, combining a realist ontology with a constructivist epistemology (Maxwell, 2012). This perspective assumes 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). In this way, participants' stories were seen to meaningfully reflect their embodied, lived, phenomenological experience, and these accounts were considered to be shaped, coloured, edited and defined by individual, social and systemic factors. In applying this perspective to SP, I hoped to "move the frame of reference away from diagnosis to one of open and context-specific curiosity" (Pilgrim, 2014, p. 13), making cautious descriptions of participants' contextually embedded experiences.

A key social context of participants' accounts was the interpersonal nature of the interview itself, which may evoke self-consciousness in participants and shape their discourse. It was also evident in some interviews that participants' stories and sense-making were influenced by factors such as the extent of their previous thinking about picking, the depth of their introspection and their wider perspective on mental health and distress. For example, some participants had read about skin picking as a distinct disorder and appeared to consider their picking within this framework. The likely impact of cultural narratives such as this was considered in the analysis, but was not seen to detract from the validity of individual phenomenology, given the complex enmeshment of self and context (Dolezal, 2015).

Design

Semi-structured Interviews

I used semi-structured interviews to offer a balance of structure and flexibility; the full interview guide is included as *Appendix 3*. This loose structure ensured that the main areas of interest were addressed with all participants, while allowing participants to use their own language and providing space for unanticipated issues (Braun & Clarke, 2013) as each interview could be adapted to the participant's experience. This was felt to be particularly important for SP, whose heterogeneity is well documented, as it was anticipated that there would be differences in which questions would be relevant across participants. My active role as researcher/interviewer meant that participants' initial responses could be probed, clarified and explored to gain a deeper and clearer understanding of participants' accounts (Legard et al., 2003).

Choice of Interview Modality

Previous research has identified shame as central in the experience of many people who problematically pick their skin (Anderson & Clarke, 2019; Snorrason et al., 2010), experienced in response to both the act of picking (theme 'I am shameful' from Anderson & Clarke, 2019) and subsequent skin damage (theme 'no one must ever see' from Anderson & Clarke, 2019). Individuals often describe efforts to conceal damage caused, such as through use of makeup and social avoidance (Flessner & Woods, 2006). Case studies have suggested that this shame may be central in distress relating to SP (Deckersbach et al., 2003; Martinson et al., 2011).

Shame is considered to be an inherently interpersonal, relational experience (DeYoung, 2015) with strong socio-cultural components, and the perspective of another person, either real or imagined, is central. As interviews are inherently interactive and interpersonal, it seemed critical to consider the impact that shame and self-consciousness might have on the current study in terms of participation, disclosure and participants' emotional safety while taking part. If not considered, these feelings may inhibit participants' responses and may exclude some individuals entirely. This has implications for both the quality of the research and my ethical responsibilities as researcher.

As the current study's qualitative approach meant that standardisation of measurement was not a concern (indeed it may be argued that standardisation is not possible in any qualitative research where the researcher adapts the interview to the participant, or where use of remote modalities mean there cannot be standardisation of participants' interview environment), I considered it most inclusive and conducive to participant comfort to allow participants to chose how they were to be interviewed. I considered that as a researcher I would individualise and adapt my approach to minimise shame during the interview, and offering choice in advance of the interview may be an extension of this participant-focussed flexibility. As individuals manage shame in a variety of ways (e.g. perfectionism, withdrawal, exposure; Kaufman, 1996), I chose to offer a range of interview modalities that could be selected according to participants' personal preferences. Options included face-to-face (where practical), *Skype* (video call or audio only), telephone, email and instant messenger [IM] (including *WhatsApp* and *Facebook Messenger*). These options were selected for providing varying degrees of exposure, giving participants control over how much visual information would be shared. Face-to-face interviews were considered to offer the least visual anonymity and email and IM interviews the most.

This decision to offer a choice of interview modalities goes against the general trend whereby researchers select a singular modality or method that they deem to be a good fit for their research. However, there have been previous examples where offering a range of interview modalities has given insight into hard-to-reach populations, such as in Dures et al.'s (2011) exploration of the psychosocial impact of Epidermolysis Bullosa, a rare skin disorder. This study included discussion of the stigma associated with visible difference and the authors note that participants' visibility to the researcher may impact what was said (Dures et al., 2011), which may be relevant to SP research. Heath et al.'s (2018) qualitative exploration of individuals' choice of interview modalities, when discussing children's burn injuries, presented four themes that influenced participants' decisions. These themes were "convenience, their ability to be open with the researcher despite any potential upset caused by the subject matter, their ability to get a "feel" for the researcher, and concern about providing adequate depth in their response" (p. 35). The authors encourage researcher flexibility and participant choice in order to maximise both recruitment and data quality in qualitative research (Heath et al., 2018).

Each interview modality offered in the current study offered its own advantages and disadvantages. Face-to-face interviews are considered well suited to questions about experience and the physical proximity of researcher and participant mean that body language and visual cues may inform the interview process (Braun & Clarke, 2013). However, ultimately no participants were interviewed face-to-face; while one participant had been willing to meet this way, it was not geographically practicable, so *Skype* was chosen as an alternative. Video calls (such as *Skype*) allow body language to be seen and interpreted (Hanna & Mwale, 2017) and have the advantage that participants may be interviewed from their chosen 'safe' location (Hanna, 2012), which may help mitigate some nervousness. As such, video calls may also be a good choice for those who are happy to be seen but live further away than is practical for face-to-face interviews, as was the case for the one participant ultimately choosing *Skype* in the current study. Online modalities of interview overcome the logistical and financial constraints imposed by distance and create opportunities for geographically isolated participants (McCoyd & Kearson, 2006).

Audio-only calls (either through *Skype* or telephone) were considered to lose the benefit of visual cues during the interview (e.g. for making in situ judgements about how to approach questions and probe answers), though this lack of visibility might be preferred where the participant does not want to be seen. Email and different forms of IM are argued to be useful where participants prefer a more anonymous context (Hinchcliffe & Gavin, 2009; McAuliffe, 2003), factors of particular relevance for SP where participants may want to evade social interaction (Flessner & Woods, 2006; Tucker et al., 2011). They also offer varying degrees of synchronicity, offering participants flexibility in how quickly they respond to questions. More asynchronous modalities may allow participants time to moderate their responses, giving them more control over disclosure of painful experiences (Egan et al., 2006) and therefore reduce risk or fear of 'over-disclosure' (Gibson, 2017). Previous research has suggested that email is a useful modality for obtaining deep accounts from stigmatised groups (McCoyd & Kearson, 2006) and vulnerable individuals (e.g. Cook, 2012; Neville et al., 2016).

Procedure

Participants and Recruitment

Table 1

Participant Details and their Choices of Interview Modality

Pseudonym	Gender	Age bracket	Interview modality
Ellen	Female	40-45	*WhatsApp*
Eden	Female	20-25	*WhatsApp*
Annie	Female	30-35	*WhatsApp*
Rebecca	Female	20-25	*WhatsApp*
Marcus	Male	50-55	*WhatsApp*
Leanne	Female	40-45	*WhatsApp*
Helen	Female	45-50	*Facebook Messenger*
Aisha	Female	25-30	Telephone
Olivia	Female	25-30	Telephone
Jenny	Female	30-35	*WhatsApp*
Lucy	A-gender, she/they pronouns	25-30	*WhatsApp*
Sam	Female	30-35	*WhatsApp*
Sky	Female	20-25	*WhatsApp*
Melanie	Female	25-30	*Facebook Messenger*
Jeff	Male	50-55	Email
Lisa	Female	30-35	*Skype*
Julie	Female	40-45	Email (incomplete interview)

This research explored the experiences of seventeen participants. Fourteen participants identified as female, two as male and one as agender. Ages ranged from 21 to 53 years, with a mean of 33.6. Participant details and choices of interview modality are given in *Table 1.* Twelve participants chose to be interviewed using the IM platforms of *WhatsApp* or *Facebook Messenger*. The remaining five participants chose telephone (2), email (2) and *Skype* (1). All selected modalities were participants' first choices with the exception of the *Skype* participant who would have preferred a face-to-face interview but it was not deemed practical. Sixteen participants contributed a complete interview and two further participants began but did not finish their interviews. One of these participants with an incomplete interview consented to the inclusion of their responses and has therefore been included in the analysis. This number of interviews was considered appropriate to ‘tell a rich story’ (Braun & Clarke, 2013), impacted by my perception of the quality of the dialogue (Malterud et al., 2015).

As SP is known to have an heterogenous presentation and I wished for this diversity to be present and acknowledged within the analysis, I used maximum variation sampling (Patton, 2002). As such, I recruited until I felt that I had interviewed participants with a range of picking styles, such as those described in previous research as ‘automatic’ and ‘focussed’ (Walther et al., 2009). My first round of recruitment only attracted one male participant, perhaps reflecting apparent female predominance in SP (e.g. Wilhelm et al., 1999). Previous research has tentatively suggested a gendered difference in the experience of SP (e.g. Prochwicz et al., 2016), so a second round of recruitment was organised to purposively increase the number of male participants in the hope of better describing male perspectives.

A website was developed to house recruitment information meaning that information about participation was available for participants to read in their own time without researcher involvement (see *Appendix 1* for website copy and recruitment materials). It was hoped that this anonymity, distance and asynchronicity might benefit recruitment, as participants could view information without obligation and ensure that they felt comfortable before making themselves known to the researcher. The website included a brief introduction to the research, a page detailing the stages involved in taking part in the research, and an information sheet to be read prior to participation. The information sheet contained information about the study’s intentions and design, participant anonymity, use of data (including use of direct quoting), right to withdraw and the nature of the interview (*Appendix 1.3*). The site also gave information about me as a researcher and my previous research so that participants would have some understanding of who they would be speaking to.

A *Facebook* profile was used to advertise the study website through posts to two SP support groups on *Facebook,* with permission of the groups’ moderators. At the time of recruitment, the groups had over seven thousand members between them and were actively used. Both groups had international membership, so advertisements were explicit that the study sought UK based participants. I was unable to find any suitably active non-*Facebook* support forums that were not connected to a business nor moderated by someone with a particular conceptualisation of SP (a concern as it may prime the nature of discussion). The study and its website were also advertised on Twitter.

An online screening survey using *Qualtrics* (https://www.qualtrics.com), combined with consent questions, was sent to participants via their preferred means (see *Appendix 2*). Participants were included in the research where they answered ‘yes’ to the questions “do you pick your skin in a way that you’d consider problematic?” and “does it cause you some distress that you pick your skin?”, thus using participants’ interpretations and definitions of ‘problem’ and ‘distress’. The decision to base this research on self-definition rather than formalised diagnostic criteria reflects the concerns about the validity of objective diagnosis and its implications (Cosgrove & Krimsky, 2012; Pearce, 2014). It was hoped that self-definition might help to avoid priming or exclusion based on aetiological or diagnostic assumptions. Use of self-definition also reflects the ethos of valuing subjective meaning in the approaches of both qualitative research and counselling psychology (BPS, 2000; Hays & Singh, 2012), and it reflects the experience that might lead an individual to seek therapeutic support. Every individual who expressed an interest in the research considered their picking to be problematic and distressing and all were invited for interview.

When registering their interest, participants selected a pseudonym for the purposes of arranging their interview and collating their data. Participants’ interview modality choices impacted their level of confidentiality to the researcher. For example, those choosing to be interviewed via *Facebook Messenger* tended to do so using personal accounts showing a name and profile picture, and email addresses often suggested identifying details. These choices were made by individual participants without researcher influence, so any decision to have this information visible to the researcher was seen to reflect the individual's prerogative. Information from these sources was not recorded nor included in the analysis.

Participant Consent and Withdrawal

Informed consent was sought from all participants via a consent form, combined with the screening questionnaire, administered online via *Qualtrics* (https://www.qualtrics.com; see *Appendix 2*). Participants were advised of their right to skip questions or withdraw fully up until the point of data analysis. This was detailed in the information sheet, reiterated in the consent form and mentioned by the researcher at the start of the interview. Previous research has noted the relative ease with which participants may withdraw from internet mediated interviews (Neville et al., 2016), as were the majority of interviews in the current study; they are very easy for the participant to terminate without consequence, either simply stopping responding to questions or by 'hanging up'. This is quite different from a face-to-face interview, where withdrawal generally requires making an active statement and managing any resulting conversation and exit. At the start of telephone and *Skype* calls, the researcher agreed actions that would be taken if the call were disconnected (such as to attempt to call again once) so as not to lose participants because of a temporary loss of signal or internet, but equally so as not to harass anyone who choose to terminate the interview and did not want further contact.

Interview guide

Pre-prepared areas of focus guided conversation and gave structure to the interview (see *Appendix 3*). This guide was held loosely (Rubin & Rubin, 2012) and questions were asked in a conversational manner, responding and adapting to the participant's discourse as far as possible. Participants were given space to raise, explore and expand on topics as they chose. The guide was developed to ensure that areas of anticipated importance would be covered. It broadly covered the more practical *features of skin picking* (including how, when and where participants picked), the *experience of skin picking* (including the emotional experience across a picking episode, feelings about the skin and damage, distress relating to picking), *coping and management* methods (including methods of reducing both picking and distress), *sense-making* (including patterns in picking and reasons for picking) and *seeking help* (including feelings about talking about picking and seeking support). At the end of the interview all participants were asked whether there was anything that they would like to say that had not been discussed, and gaps identified by participants informed future interviews. For example, a participant in an early interview felt that they should have been directly asked about the impact of life events on their picking. This was included as a question in subsequent interviews.

Managing Risk

This study considered the experiences of those who problematically pick their skin, which has been shown to cause significant distress (e.g. Anderson & Clarke, 2019). As such I considered there to be a potential for psychological harm should the research be poorly managed. At the time of interviewing I had over five years of clinical experience working as a counsellor and trainee counselling psychologist in paid and voluntary roles. This included work for the NHS, work within specialist organisations and private work. I had experience of working with distress, shame and psychosocial avoidance, and a small amount of experience of working with SP as a primary or contextual issue. I drew on this experience while conducting my research and used it to inform a sensitive, compassionate and appropriately tentative approach to my interviews, while holding in mind issues of risk.

I anticipated that participants may feel shame during the interviews, and hoped that this would be lessened by allowing them to manage their exposure through making their choice of interview modality. As well as likely benefiting the quality and accessibility of interviews, it was hoped that offering participants this choice would help to create a ‘tone of respectfulness’ (Hamilton & Bowers, 2006) and increase participants’ agency (Hanna, 2012). This was hoped to reduce participants’ feelings of vulnerability and gave fuller meaning to the idea of giving participants ‘a voice’ (Seymour, 2001). Participants were free to pause the interview where they wanted a break and were free to stop the interview at any point. Several participants, all of whom had chosen asynchronous interview modalities, used this right to engage and disengage with the interview as they were able, managing their participation around other needs, suggesting that asynchronicity made exercising the right to pause the interview more possible.

A debrief page was set up on the research website and a link was sent to each participant at the end of their interview, including when the interview was left incomplete (see *Appendix 1.7*). The debrief was worded to normalise participants' experiences and encourage self-care and self-compassion. Development of self-compassion is of therapeutic value where there is shame and self-criticism (Gilbert & Irons, 2005) and may help to reduce shame in body image dissatisfaction (Ferreira et al., 2013). The debrief also included ideas about recognising picking triggers from Habit Reversal Therapy (Azrin & Nunn, 1973), which may be helpful for SP (Teng et al., 2006). The debrief offered some suggestions for seeking support and normalised therapeutic treatment seeking. It also prepared participants to talk confidently about their picking in the case that their therapist was inexperienced in working with SP, as is common and may be experienced as off-putting (Gallinat et al., 2019b; Tucker et al., 2011).

This research was conducted in adherence to The British Psychological Society's (BPS) Code of Ethics and Conduct (BPS, 2018) and Code of Human Research Ethics (BPS, 2014). Full ethical approval was granted by the Faculty Research Ethics Committee in June 2018 (see *Appendix 5*).

Interview Transcription

Interviews were fully anonymised. Participants' were given a pseudonym, either of their choice or chosen by the researcher. Any identifying information (such as age, locations, profession) was removed from the interview transcript or substituted with generic or broad alternatives. Substitutions were particularly helpful where inclusion of the information was necessary to understand the discourse, such as where an age was given to imply youth, or a profession given to imply specialist knowledge. Direct quoting has been used in the report, which is vital to the approach used and honours the intention to represent the voices of participants. Only shorter quotations of a few sentences were used in the write-up so that individuals would not be identifiable by their story.

Skype and telephone interviews were orthographically transcribed for analysis. Email and IM interviews did not require transcription as they were already in textual form, so were copied to a new document verbatim. Characteristics of expression and of the interview modality (such as informal language or grammar, or text-speak in IM interviews) were left as they capture an important element of expression (Braun & Clarke, 2013), but self-evident typos were edited to better represent apparent intended meaning and for ease of reading.

Process of Coding and Developing Themes

Coding and analysis were guided by Braun and Clarke's (2006, 2013) guidelines for using thematic analysis. Each stage of the coding and theme development process described below was clearly documented ensuring that the evolution of themes was clear and traceable. This helped to ensure research rigour and means that process and dependability may be demonstrable.

I familiarised myself with the data by reading the transcripts several times while making rough notes. As data collection took place over a protracted period of time, coding of transcribed interviews began before the full dataset was available. Transcripts were read line-by-line and initial codes were written in a column alongside the transcripts. These codes were refined and added to as interviews were revisited over time (see *Appendix 6* for examples of coded extracts). Throughout this process I was careful to note and re-read areas of relatively sparse coding to ensure they were not neglected. My supervisor also independently coded three of the interviews for purposes of reflexivity, providing an interesting alternative standpoint. I cross-referenced our two perspectives to notice and reflect on our differences of perspective.

Once initial coding was complete, I looked for larger patterns across the dataset and grouped the codes into themes (Braun & Clarke, 2006). I found it helpful to think of the theme titles as spoken in the first person, and imagine participants saying them, to check whether they reflected the dataset and participants' meanings. I tried not to have my coding and themes steered by ideas, categories and definitions from previous research, to allow a more inductive, data-driven approach, while recognising my role as researcher in co-creation of themes (Braun & Clarke, 2013). However, there were times when the language of previous research appeared a good fit, such as in the discussion of 'automatic' and 'focussed' picking. Given that the experience of SP is an under-researched area, particularly from a qualitative perspective, and that the aim is for this study to contribute to therapeutic developments, themes were developed with the entire dataset in mind (Braun & Clarke, 2006), such that they would more likely be relevant to someone presenting in therapy for help with SP. There was clear heterogeneity in the interviews, and in cases where I have taken a narrower perspective on an experience (such as when describing an experience only true for some of the participants), I have tried to give a loose indication of prevalence and alternative views.

I created a large 'directory' of themes and smaller sub-themes, with the relevant participant quotations filed under each theme or sub-theme heading (see *Appendix 7* for examples). This helped me to adjust theme titles, boundaries and position, meant that I could check that themes were faithful to the data at a glance, and was of practical help when writing the analysis.

The process of coding and developing themes was intended to have both descriptive and interpretive elements (using Braun & Clarke's definitions, 2013). The descriptive element was intended to represent what participants said, while the interpretative element drew on my subjectivity to consider less directly evident patterns, such as those that might be influenced by social context or forces such as shame. This interpretation was of particular value to the current study as participants often struggled to find words for their experience and several reported or implied that they did not understanding the mechanisms of their picking. An interpretative stance meant that I could develop ideas about what they *were* able to describe and consider the relationships between these experiences, making sense of them alongside previous literature (Braun & Clarke, 2006). Writing was considered an integral part of the analysis (Braun & Clarke, 2013) and it helped me to adjust the boundaries of themes, notice more latent patterns and considered how themes and their content were related.

Given the known heterogeneity of picking I was keen to make sure my analysis did not become skewed towards one type of SP experience to the detriment of another. I actively looked for participant experiences that diverged from those of the developing themes (with similar intentions to a ‘deviant case analysis’; Lincoln & Guba, 1985) so that the final analysis would represent themes in context and with balance. When adding quotations to the prose of my analysis I re-read them in their original context to ensure that my representation of their words appeared to be a credible reflection of what was said.

Researcher Reflexivity

Subjectivity as a Resource

I considered my subjectivity to be a resource when conducting interviews and analysing data (Braun & Clarke, 2021; Gough & Madill, 2012). It guided my judgement when interviewing, helping me to respond to participants’ explicit, implicit and more verbally concealed distress. I allowed aspects of my own experience to resonate with those of participants meaning that I could listen to their stories with empathy and a genuine curiosity. During analysis, themes were actively created and categorised, demanding my use of self (DeSantis & Ugarriza, 2000). I sought to interpret the data rather than simply describe it, which necessarily requires acknowledgement of both researcher and participant subjectivity. I strongly feel that we can only make sense of another’s story by relating it to our own phenomenology (Smith & Shinebourne, 2012), and that we re-construct their stories on frameworks formed by our own subjective experience. As such it is useful to be aware of my personal experiences and assumptions.

Personal Reflexivity

Some level of skin picking is a very common (if not universal) activity, and as a researcher and human being it would be impossible to come without either experience or preconceptions about the behaviour. From my adolescence through to adulthood I have a testing relationship with my skin, which is often dry, sensitive and prone to acne and inflammation. I have had periods of time when I have been preoccupied with my skin and its appearance, and I can relate to the idea of getting stuck in front of a mirror with intentions to improve my skin. However, I feel that my experience of picking has been largely dermatologically driven and that I have tended to keep it relatively proportionate, and any picking has waned with improvements in my skin's general condition. As such I do not identify it as being a problem nor has the picking itself caused distress, meaning that I would not consider it 'SP'. However, I do feel that I can relate at least in part to some of the experiences that literature has described, such as preoccupation with skin, a sense of shame in damaged skin and need to conceal imperfections. Before interviewing for the current study, I spent time considering my experience, thoughts about and attitudes towards picking, including through personal therapy. I found it helpful to remind myself that while I did have some experience of 'small-p' picking and its phenomenology, as do the vast majority of (if not all) humans, I should be careful not to assume any 'knowledge' of problematic SP, but should rather use my experience as an opportunity to build empathy and understanding for the individuals that I would interview.

I was conscious that, whichever means of interview participants chose, the interviews would be a social interaction discussing a subject matter often considered shameful or embarrassing. As shame is an inherently social experience that requires the real or imagined perspective of another, I understood that I would take the role of the 'other' in the interview dynamic, and my presence could set a scene for either shame or acceptance. I was very conscious of this during the process of recruitment and interviews, and I strove to ensure that I was conspicuous in my neutral acceptance of participants' experience. This meant focusing all my energy and interest into their story, and being transparent in my engagement so that participants could see that I valued their experience. When interviews were asynchronous, I did my best to respond quickly, particularly after participants had told me something upsetting or particularly personal, to make sure they felt immediately heard and were not left wondering what I thought.

Given that I was to be asking participants to discuss their physical bodies, I anticipated that they would be conscious of their visibility and appearance during the interview. Indeed, giving participants scope to avoid this visibility was at the heart of the rational for offering multiple interview modalities, and ultimately only one participant was interviewed using a visible modality. Given that body shame is associated with both real and imagined interpersonal visibility (e.g. Charmaz & Rosenfeld, 2006), it seemed reasonable to consider that my own physical appearance might be significant within our dynamic. A therapist's physical appearance has been shown to influence work with individuals with eating disorders (Lowell & Meader, 2005), which may be considered phenomenologically related to skin picking by way of body shame (Calogero et al., 2005; Skårderud, 2007). It seemed pertinent to be aware of presenting myself with visible 'neutrality', such as by wearing minimal makeup, though I appreciate that this definition of 'neutral' is itself subjective and open to debate.

Skin picking is more frequently reported among women. It is not known whether this high prevalence is mediated by biological or social factors; women may pick more, may be more distressed by their picking or may be more willing to disclose their picking. Gender is also considered to be a significant factor in the experience of body shame (Grabe et al., 2007). Western beauty and bodily ideals traditionally differ for men and women, and the female experience of objectification by cultural politics is well documented (e.g. Bartky, 1990; Berberick, 2010). Furthermore, gender may influence disclosure of distressing information (Kahn & Hessling, 2001), whereby men are less forthcoming. I have anecdotally noticed men being self-conscious of their gender when posting to SP support forums, such as in apologising to the group for their gender or expressing shame in their use of concealing makeup. It seemed prudent that I be aware that my sex, gender and my attitude towards disclosure and/or shame are social dynamics and consider the impact that they may have on my research (Manderson et al., 2006).

The interviews explored the experience of support-seeking relating to SP. I am a trainee counselling psychologist and I am aware that I have a faith in the value and efficacy of appropriate psychological therapies. Additionally, I have a preference for working with psychological formulation (e.g. Johnstone, 2018) rather than diagnosis. This preference has roots in my training, my work as a therapist and my experience of sense-making around personal distress. I am aware that this preference has shaped my research aims and design, and is congruent with my choice to not use diagnostic criteria to define the sample. It is likely that both my belief in psychological therapy and my preference for a formulative approach would also influence my interview conduct, so I reflected on the distinct purposes of my therapeutic work and my research (Thompson & Russo, 2012), and was careful to ask participants simple, open questions when asking for their thoughts about treatment and diagnostic sense-making.

Analysis

Introduction to the Participants and Interviews

Across their interviews, participants offered a wealth of insight into their individual experiences of SP, with apparent commonalities in experience alongside clear divergences. The themes presented in this analysis offer particular value to both researchers and psychological therapists, such as that they cover new ground, add rich participant voice to concepts that have received little qualitative exploration, or suggest therapeutic inroads. This brief introductory section is intended to give some context to these themes and to suggest who and what kind of picking they relate to. The current study’s use of expansive self-definition means that the nature and range of participants described may seem more ambiguous than in studies using more formal definitions in their sampling (though, as discussed previously, these definitions are often unclear and are not without flaws). As such, this section will briefly depict participants’ picking behaviours and the ways in which it was problematic, excluding those areas raised in more depth in the analysis, to give a sense of who the sample represents.

There was variation both between and within participants in terms of picking bodily locations, awareness of picking, picking intensity and level of distress. Between them, participants described picking every bodily surface, with the face, fingers and legs most commonly mentioned. Some participants described use of tools such as tweezers and blades, and some included behaviours such as biting the skin or removing hair growth from beneath skin within their descriptions of picking. Some felt that their drive to pick focussed upon one or two bodily areas, while others felt that the urge to pick more generally across their bodies.

In previous SP literature, especially where sampling is based on DSM-5 (APA, 2013) criteria, individuals have been excluded based on the presence of other diagnoses (see ‘*Defining Problematic Skin Picking’*). The current study did not make these exclusions, preferring to represent individuals distressed by SP, however they might present. In the current study, one participant related their picking in part to autistic stimming, and a couple suspected or believed it to relate to body dysmorphia, both of which are named exclusions in DSM-5's criteria for SP (APA, 2013). Several participants mentioned dermatological conditions such as psoriasis, eczema and keratosis pilaris impacting their picking, though none considered their picking to have a solely dermatological aetiology. Two participants described self-injury, one as distinct to their SP and one as overlapping with their SP (it created the wounds which were then picked). Several considered their SP to relate to OCD, either as a symptom or through shared characteristics, and several described their SP as an addiction or as having addictive qualities.

Some participants used their interview to talk about immediate experiences, reflecting predominantly on their picking in the present or recent past, while others felt that their picking had been at its worst in the past and spoke with more retrospection. Several participants had experienced a psychological therapy which was relevant to their picking (such as for low mood which the participant deemed related to picking), though it was rare for participants to have directly discussed picking in therapy.

Participants' picking broadly reflected previous research's categories of automatic, focussed and mixed picking styles (Walther et al., 2009). Some described focussed picking, such as Helen's example of how she noticed an imperfection on her skin and *'specifically went to the bathroom to [pick]'*. Descriptions of more automatic picking included that it felt '*habitual and so ingrained*' (Ellen) and movements seemed involuntary, such as in Melanie's description of '*wandering'* hands and how Rebecca considered picking to be '*a natural action… [that] happens as easily as breathing*'. The distinction between the automatic and focussed picking became more complex when considering a picking episode over time; unconscious, general skin-scanning sometimes became conscious when a picking target was found, and many continued to pick despite this awareness. Conversely, almost all participants whose picking began with focussed intentionality then described 'zoning out' and picking more '*passively'* (Lisa) or '*on autopilot'* (Jenny), where behaviour appears more automatic ('zoning out' is described in this analysis' second overarching theme, '*Switching Everything Else Off')*.

The extent of skin damage directly caused by picking varied between participants but often included inflammation, bleeding and scarring, and sometimes more risky secondary consequences such as ulceration and infection. For some, pain impaired everyday activities such as holding things, walking and washing, though others considered their skin damage to be manageable. Several participants considered their picking to be adversely '*time consuming'* (Eden) to the point of significant interference with their life*: 'it takes up so much of my life… i waste so many hours damaging my skin for no good reason… [I pick for] hours a day at least'* (Sam).

The following analysis presents three overarching themes that illustrate three dimensions of the problem presented by skin picking. These overarching themes and their constituent themes are summarised in *Table 2* below.

Following the main analysis, I discuss participants' reflections on the interview process and their choice of interview modality. Given that offering participants choice of multiple interview modalities is not the norm (Heath et al., 2018), it seemed appropriate to allow participants the space to directly discuss their rationale for and experience of their chosen modality. Previous research suggests that considering participants' experiences of research participation may be useful for the development of ethics, processes and practice in qualitative health research (Peel et al., 2006). Three themes relating to participants' choices are discussed: 'Practicalities and Participant Convenience', 'Social Comfort and Confidence', and 'Thinking Space'.

Table 2

Summary of overarching themes and their constituent themes, illustrated using participant quotations. Italics indicates quotations that are directly presented within the analysis and ‘…’ indicates omitted text.

Overarching Theme and Description	Theme and Description	Example Data Extracts
The Voice that Permits Picking: Cognitions Drive Picking and Undermine Resistance. Participants’ picking was driven by cognitions and circumstances that permit or accommodate picking, and that diminish the will to stop.	**Skin Texture Must Go** Thoughts and attention relating to the skin motivated participants’ picking and its continuation. Cognitions seemed particularly focussed around skin texture being intolerable and feelings that it could not be distracted from.	“*I hate the feel of lumps or unevenness on my fingers*” (Julie) “I believe all these bumps and raises are imperfections on my skin that are *not acceptable*” (Melanie) “[my mind says] Get the *gross* out, theres ones youve missed … ill know that there is yuck under my skin.” (Sam) “I’m also *most alert for imperfections* during times where I feel eyes will be on me … perhaps wanting to appear polished and perfect so I’ll just ‘get rid of these imperfections’ first. (Ellen) “[I think] stuff like ‘I’m just going to do a little bit’ then you end up doing more than what you were supposed to do … And you see something else and things get out of control and like ‘oh well, here I am.’” (Olivia) “it's like theres something else sat on my skin that shouldn't be there, and until I pick or pull it off I'm just *so conscious of it being there …* making myself bleed or hurt doesn't stop it, I'll only stop once *all the uneven surfaces are gone*.” (Sky) “It’s like eating chocolate and wanting more because it tastes so good.” (Lucy)
	‘Oh Well’ and ‘So What’: Resignation to Picking Many participants described cognitions that contributed to a resignation to picking, such as that picking was inevitable, tolerable, excusable or manageable, permitting themselves to pick. Several reported a reduction in picking where it was less manageable.	“*I’d have to pick it sooner or later, so I might as well get it over and done with*.” (Rebecca) “I think maybe when I started it all I thought *"so what" to if it was going to make my legs look a mess, because nothing would have made me like my body so why not do something that could cause scars or whatever ...*” (Jenny) “*I think I can link it with self worth too. I’m feeling down at the moment, being hard on myself so I start picking … I think I take out my frustration about feeling low by picking or biting myself. It’s almost like I don’t matter so if I hurt myself that’s fine*.” (Jeff) “…if I have picked quite badly and lots of red sores or fresh marks, I often find for a few days I pick in the same are ... Maybe a little bit of a *what the hell attitude* as I’m going to *have to cover it anyway …*” (Annie) “I do pick quite aggressively [in hidden areas] because I think *no one will ever see* it” (Lisa) “*The only way to stop me is basically to shame me haha* … As it’s a furtive endeavour, being called out would be humiliating enough to curtail it” (Ellen) “I *steer clear of my legs now*, as I had a site on each leg … that got infected and ulcerated” (Marcus)
	Picking because I Can: Permissive Circumstances For many, picking would	“[I pick] Any time when I’m concentrating on something and not using both my hands really I suppose ... *if I’m in a situation where I can, then I do*” (Leanne) “if my hands are left *idle* I'll find myself picking nearly all the time unless theres something to distract me … It feels like it's *as soon as my hands aren't doing anything else, it's a matter of time before I end up picking at*

	happen whenever circumstances allowed, as if the opportunity to pick were itself a trigger, filling free time and free hands.	*them*.” (Sky) “It’s *something for my hands to do* [when I’m bored]” (Rebecca) “*if im not distracted by something else then i am [picking] or thinking about picking*” (Sam) “I purposely don’t get up ridiculously early like I make sure I’m up then have to get ready then leave so I don’t get side-tracked [and pick].” (Aisha) “Having a reason to get up, dressed and out is a great way of avoiding get stuck in front of the mirror.” (Annie) “… being alone only increases the chance of me picking … Because I become more *self-focussed*.” (Olivia)
Switching Everything Else Off Participants described their picking as having dissociative qualities where they ‘zoned out’ away from senses and awareness. Picking often occurred alongside feelings of stress or distress, and the experience of ‘zoning out’ was often reported to give participants relief.	**Zoning In to Zone Out** Participants described intense attention on the act of picking, and reduced peripheral awareness. Some described a complete disconnect, while others described more awareness of competing thoughts but struggled to act on them.	“[my picking is] really weird tbh, its devoid of emotion totally ... it is like *pure focus*” (Marcus) “I guess you could say it’s like a *trance state … in that moment in time nothing else matters apart from what your picking and where your picking*” (Melanie) “*I feel like I’m just switching everything else off … it’s all about the picking when I’m picking, it’s not about anything else … it’s blocking everything out for a minute. It’s like putting the pause button on almost, stopping the world* … once I’m doing it it’s almost like, I don’t know, my hands just kind of take over” (Lisa) “*I can sort of zone out of it and I don’t kind of realise how long I’ve been doing it for, and then I don’t know what it is, something will kind of go off and I’ll realise what I’ve done and I’ll see the redness and the sort of, the blood an things like that, and then I’ll be like “crap what’ve I done”*.” (Aisha) “I think because it’s pain free, I’m probably quite disconnected to it, my level of focus is detailed so, yes I guess I forget *that what I’m doing is attached to my actual face*.” (Ellen) “you could be listening to yourself … but are you going to do as your thoughts say?... “don’t do it because you’re going to regret it, oh I’m doing it, no I sh-” … it’s like a *battle*.” (Olivia) “*I … will tell myself to stop but won’t physically be able to snap myself out of it*” (Eden)
	It Comes with Negative Emotions Participants noticed patterns in their picking relating to contextual stress and distress, with trauma and more general stressors often worsening picking, though picking also occurred independent of mood.	“*Usually it comes with negative emotions. Stress, annoyed, worried, upset. That’s when it gets worse*.” (Rebecca) “I think my picking … was *a symptom of the distress, despair and utter hopelessness* I felt then.” (Lucy) “I had a lot of trauma in my life the last 15 years but *learning how to deal with that* has probably helped. I think I’m left with more of a habit now” (Helen) “*one day I can be like ‘oh no [skin texture is] fine’ and … it can be the exactly the same the next day and I’m like ‘no, that has got to change’* … I think it’s all dependent on my mood ...” (Aisha) “the amount of damage you create is detrimental to the way you look which is so closely linked to how you feel about yourself, and the cycle completes because you feel *guilty and worse that you did it to yourself .... which makes you feel like picking!”* (Annie) “I personally get worse when I’m depressed but I still pick *when I’m fine*” – (Melanie) “I feel like it’s a symptom maybe of something else … but I feel that it becomes like *its own entity*.” (Lisa)
	Reducing Emotional and Mental Noise The attentional	“It is almost a *distraction* thing. I seem to have a couple of defaults when I’m feeling low like this and picking is one of them.” (Jeff) “*…I guess the stimming (which the biting/picking is part of) redirects my attention onto something I can handle*

	experience of picking offered participants emotional and mental relief. Many reported picking as a means of coping or relaxation.	*when I can’t handle the world around me*.” (Lucy) “*The act of picking focuses my mind in a singular thought and task, giving my brain a much needed break from itself*” (Marcus) “You kind of get a bit lost in yourself and sometimes *forget* about your *day to day things*.” (Helen) “I know that sometimes if I’m *working through I problem* in my head I will default to picking ...” (Ellen) “[after picking] *I say to myself “what have you done” … and then there’s the flip side of “it helped be out of what I needed to be out of at the time”* .” (Aisha) “… it’s a way of releasing all my stress, sadness and anxiety … it’s better than me self harming” (Melanie) “[Picking] helps me relax … once [my son’s] in bed it's *my time to chill out*.” (Jenny)
I Worry About People Looking and Judging Me: Distress in how Picking is Seen Much of participants’ distress seemed mediated by beliefs about the appearance of picking and its damage in the eyes of others.	**Shame of Picking** Participants were self-conscious of the appearance of picking and skin damage, leading to avoidance and concealment. Underlying cognitions included that skin damage may be mistaken as infectious and that picking revealed low self-control.	“*If I’ve had a bad pick I will cancel plans and avoid anyone seeing me, I won’t even answer the door. If I do have to go out my anxiety is through the roof* … [After picking] I feel depressed and just want to climb into bed … It *makes me hate me and the way I look*” (Helen) “*If it didn’t leave a mark I wouldn’t genuinely care in the slightest …*” (Ellen) “I think it definitely affects my relationships … when i’m with [my boyfriend] I find it really embarrassing and find myself avoiding looking him in the eye when I don’t have makeup on” (Eden) “I hate it. It looks so red and spotty and sore. Its embarrassing people seeing my arms like that … [they might think] that ive got a *bad rash* or infection or something” (Sam) “[people might think] that I've got *some weird disease*, or that I've picked for attention or … I'm odd” (Jenny) “I have had hospital treatment for an infected finger wound. Generally I try to treat them myself – *it’s really hard to try to explain how self-inflicted wounds have happened*.” (Julie) *“I’m ashamed that I haven’t been in control of myself enough to not do it.”* (Leanne)
	I am Misunderstood Participants were often distressed and/or frustrated by feeling misunderstood by other people, and this impacted on speaking about picking and help-seeking. Participants reported feeling relief and validation when they did feel understood.	“…aside from my boyfriend nobody else really understands what it’s like from my perspective, my parents always tell me to ‘just stop picking’ and some friends will give me skincare tips or tell me to eat healthier ‘to get rid of acne’, so it’s annoying feeling misunderstood …” (Eden) “When people mention [my picking] I’m made to feel that I shouldn’t do it. There seems to be a lack of understanding. *Like it’s something I should be able to control and is easy for me to stop doing*.” (Jeff) “…there seem to still be many professionals who aren’t interested or don’t want to take the time to try and understand it.” (Leanne) “*to me [picking] is a problem, yet [my psychiatrist] just made it seem like it was just nothing … I'd just like them to take it seriously, rather than making me feel like I'm just being silly and it's not a problem at all*” (Jenny) “*It’s just more hassle than it’s worth* getting into conversations about it lol” (Rebecca) “*when I found the Facebook group, it felt like suddenly I wasn’t alone in this.*” (Sky) “Ive had lots of people shout at me, tell me its bad, its self harm, but my partner is one of the first to actually go, no its a disorder, you cant help it, we can help you” (Sam)

The Voice that Permits Picking: Cognitions Drive Picking and Undermine Resistance

A pattern throughout the interviews was a conflict between the drives to pick and to stop. Some felt this division so distinctly that they described it as a ‘*running argument’* (Marcus) or ‘*battle’* (Olivia) between separate voices. Lisa used the metaphor of feeling split into two people: *‘…like there’s the person that’s healing from the picking and is feeling positive and hopeful about it, and then there’s the person that turns around and stabs you in the back and starts doing the damage all over again’*. Melanie gave words to these two perspectives:

> *I would say I have two minds when I’m in that trance like state [picking], it’s like I have an angel and a devil, the angel is telling me to stop picking I’m only making it worse and that it’s hurting me I have to stop and then there’s the devil telling me to keep going look how much you’ve picked and how much stuff you’ve got out your skin it makes me feel better, I’m usually bleeding a lot before I’ll convince myself that it’s time to stop and step away and that’s when I start hating myself for what I’ve just done.*

The purpose of the current overarching theme is to give detail to the voice that, in the moment, drove participants’ picking and allowed it to happen despite the distress that often followed. It seeks to describe the way that participants rationalised, justified and permitted their picking in the moment, and how the ability to integrate and accommodate picking (or the belief in the moment that it may be accommodated) may add to the drive to pick or diminish the will to stop.

The first theme in this section, ‘*Skin Texture Must Go’*, describes the cognitions that appeared to motivate picking and its continuation. The second theme, ‘*’Oh Well’ and ‘So What’: Resignation to Picking*’ considers how many described a lack of resistance to picking in the moment, permitting themselves to pick. The third theme, ‘*Picking Because I Can: Permissive Circumstances*’ describes how, for many, picking would happen wherever circumstances allowed, as if the opportunity to pick were itself a trigger, filling free time and free hands.

Skin Texture Must Go

This theme considers how cognitive processes, such as thoughts and attention focussed on the skin, seemed to both trigger picking and make it difficult to stop once started. Cognitions seemed particularly focussed around skin texture being intolerable and feelings that it could not be distracted from. Participants unanimously described the want to smooth skin texture as an immediate precipitator of picking, and saw resulting skin damage as collateral to picking rather than intentional harm. Julie described how her desire to smooth texture meant that her skin could not heal:

> *My fingers are by far the worst – I don't think there's ever been a time I can remember (even in young childhood) when I haven't had wounds all around the top of all my fingers… When the skin that's been picked goes hard, I'm compelled to pull at that too, because I hate the feel of lumps or unevenness on my fingers. This means the worst wounds are pretty much never healed.*

While this smoothing of texture was far from being the sole reason given for picking, all participants described it as significant in the moment before picking. A couple of participants did not identify any cognitions relating to skin texture; Rebecca said that there was *'no thought process to it, just get rid of it'*. However, some participants did identify cognitions that drove their desire to smooth skin, such as that texture was '*not acceptable'* (Melanie), '*gross'* (Sam) and *'shouldn't be there'* (Helen), and that picking was an act of improvement or management of their skin. Several participants used words such as '*cleaning'* (Annie, Lisa) to describe the process, implying that texture was dirty or unhygienic.

A few participants described how social experiences in which they felt scrutinised made them '*more alert for imperfections*' (Ellen). Sam felt that her view of her skin was impacted by her mum '*because she picked at me, telling me I needed to get them'* and Melanie considered that clear-skinned images shared on social media meant that '*in a way I feel it's not socially acceptable [to have imperfections]*.', suggesting that others had instilled in them a negative meaning to skin texture.

However, while clearly significant for some, the drive to pick was not always subject to social influence; Lisa explicitly discounted social impact, saying that she had '*never been conscious of what people can [see]… it's not about how it looks, it's about how it feels to me, I think'*.

Problematic picking was frequently characterised as picking that could not *'stop at one'* (Annie). One route whereby picking continues was that, for many, the act of picking involved scrutiny of the skin with a *'[detailed] level of focus'* (Ellen), maximising sensory information about the skin and causing them to '*see something else'* (Olivia) and create a cycle of picking. Several participants of the current study reported having attempted to reduce sensory information to reduce picking, such as by wearing gloves, dimming lighting, removing mirrors and covering fingers with plasters. The idea of reducing sensory information seemed to relate to 'stimulus control' techniques (e.g. Snorrason & Woods, 2014; Jafferany & Patel, 2019), intended to reduce picking by creating a physical barrier and reduce information from scanning. However, this approach assumes that picking occurs as a direct habituated response to contextual or sensory cues and does not see attention paid to skin as a motivated process. Participants generally considered these techniques only helpful in the short-term as they '*cheated'* (Lucy) or would '*relent'* (Rebecca), or felt unable to use the technique in public environments.

Another route whereby picking continued seemed to be a draw to having picked to a finite point, such as when '*something comes out'* (Leanne) or *'all uneven surfaces are gone'* (Sky), indicating completion. It was not always clear whether these cognitions relating to completion were separate from the motivation to achieve smooth skin (it seems understandable that someone set against texture might want to remove it all rather than some), but some seemed motivated by a greater goal. Sky explained that '*I'll end up carrying on because it's like I've not finished'*, and Lisa described satisfaction in feeling '*really diligent'* when picking her skin completely and '*perfectly'*.

Participants described agitation, preoccupation and '*nagging'* (Sam) when resisting the urge to pick at skin texture, being '*so conscious of [something that their picking would target] being there'* (Sky). Some implied that discomfort came from the deferring of the positive gratification of picking;

Annie described being *‘antsy/edgy wanting to get at [skin texture]*’ and Jenny experienced *‘a similar craving to wanting a cigarette’*. Similarly, some participants described feeling a ‘*rush’* (Leanne, Jeff) when removing texture from the skin, which Lucy likened to ‘*eating chocolate and wanting more because it tastes so good’*.

While the drive to smooth skin was compelling in the moment, participants viewed these cognitions with critical distance when not picking. Many considering self-criticism of texture to be disproportionate and not ‘*reflect reality’* (Olivia), acknowledging the irony that their picking, intended to improve skin, achieved ‘*the opposite’* (Eden). Ellen described holding these two perspectives: *‘I squeeze pores… Irrational brain equates this with ‘clearing my skin’ – rational brain recognises that the behaviour is the opposite’.*

‘Oh Well’ and ‘So What’: Resignation to Picking

The previous theme describes thoughts about skin texture that appear to positively motivate picking. Alongside these cognitions, participants frequently described cognitions that seemed to contribute to a lack of resistance to picking, or a resignation to picking, such as that picking was inevitable, tolerable, excused or manageable. These are discussed within the current theme.

Some participants felt that resisting the urge to pick would make little difference. For a couple of participants, resistance seemed pointless as they felt that they would pick eventually. Rebecca talked about how she’d ‘*have to pick it sooner or later, so I might as well get it over and done with’*, suggesting that she felt that the urge to pick would persist and that picking was inevitable, giving little reason to resist. More prominent in the interviews was that participants felt that resisting would make no difference to their body or how it appeared, either because they did not like their body anyway, felt their skin was already damaged or knew that they could hide the damage. These are discussed below.

Participants sometimes diminished the significance of the harm and hurt that their picking caused which meant that picking was less inhibited. Jenny related the start of her picking to a general dislike for her body, recalling ‘*so what to it if it was going to make my legs look a mess,* *because nothing would have made me like my body so why not do something that could cause scars or whatever'*. Jeff also described this resignation when asked why he picks, connecting his feelings of low self-worth to an acceptance of picking, as if he did not see himself and his skin as important enough to warrant resistance:

> *I think I can link it with self worth too. I'm feeling down at the moment, being hard on myself so I start picking… I think I take out my frustration about feeling low by picking or biting myself. It's almost like I don't matter so if I hurt myself that's fine.*

Olivia wondered whether labelling her picking as '*punishing'*, thus framing the picking as aggressive, might help her to be more conscious of the harmful reality of her picking, rather than dismissing the picking as acceptable, and so help her to reduce picking.

Previous skin damage meant that some participants felt they had little to lose by picking, as subsequent picking would not make much difference. Lisa described feeling '*what does it matter if I just carry on now it's already messed up?',* and Annie talked about having a '*what the hell attitude'* to areas that she had already picked as she would *'have to cover it anyway*', implying that skin damage permitted further picking.

A few participants picked more or more aggressively at areas of the body *where 'no one will ever see [the damage]'* (Lisa), suggesting that the damage was of less importance if it could be hidden. This impact of visibility to others suggests that the anticipated responses of others serve as a deterrent to picking, and that the ability to hide the act of picking or its damage removes an incentive to stop, and thus disinhibits picking. Ellen, who joked that *'the only way to stop me is basically to shame me haha'*, compared her picking to verbal tics that she had in childhood, wondering whether the '*unhidable'* nature of the tics was a factor in her stopping them, while she could continue to *'pick skin in secret as [it was] noiseless*'. This discretion may relate to how the majority of participants, particularly those who described more focussed picking, talked about doing it when in places where they would not be seen. Those who noticed that they picked when visible to others tended to pick at areas where they could do so discretely, such as their fingers, or bodily areas where the movement to pick was more '*natural feeling'* (Lisa) or socially acceptable, suggesting that picking was less inhibited where it could be discretely incorporated into bodily movements. This is not, however, to say that participants only picked in unnoticeable or concealable ways; they often picked beyond their initial target, and many described losing track of the harm being caused while picking.

Annie was one of a couple of participants who had purposefully exposed herself to the inhibiting impact of visibility. She had joined a swimming club, and she attributed a reduction in her picking to a combination of the visibility of her skin as an incentive to not pick and the stress relieving quality of exercise. These examples begin to illustrate the shame and discomfort of picking being seen, and shows how, while concealment might offer welcome relief from self-consciousness, for some it may also give permission to pick.

A final character of participants resignation to picking was an acceptance of picking or a feeling that it was not a priority concern, either because it was felt to be manageable or because it was identified as serving a beneficial or '*adaptive'* (Lucy) function, such as providing emotional relief (see overarching theme '*Switching Everything Else Off*'). The idea that picking was allowed where manageable was supported by how, for some, it *was not* allowed where it had become *un*manageable, such as through risk of more permanent damage. For example, Marcus talked about how he '*[steers] clear of my legs now'* due to infection and ulceration, implying that the unmanageable nature of his leg picking proved to be a sufficient deterrent, whereas the relative manageability of picking elsewhere made it much harder to resist. Again, this is not to say that all picking damage was manageable, but that it was deemed to be manageable in the moment. Participants often lost track of the damage caused.

Picking Because I Can: Permissive Circumstances

Both automatic and focussed picking were often described as 'default' behaviours that were gravitated towards in any time or space where it can be accommodated, or where measures were not actively taken to resist. Leanne explained that '*if I'm in a situation where I can, then I do*', suggesting that being 'able' to pick is a direct predictor for picking without intermediaries. Some described how resistance in situations where picking is possible required constant vigilance; Leanne talked about this resistance being a tiring and active process, requiring '*physical and mental effort which needs concentration to maintain'.*

Several participants noticed that they picked more when their hands were unoccupied, and Sky considered that '*idle'* hands invariably led to picking: '*As soon as my hands aren't doing anything else, it's a matter of time before I end up picking at them*.' Others noticed that they picked more when *'bored and don't have much to do'* (Eden) or when engaging in more sedentary activities, such as watching television. Rebecca coupled boredom with a lack of activity, explaining that picking is *'something for my hands to do'* when bored, and Sam described how picking fills all unoccupied time: *'if im not distracted by something else then i am [picking] or thinking about picking'*. Similarly, participants frequently mentioned picking less when busy, either because activity distracted their minds or hands from picking or they practically had less time or opportunity to pick. In attempt to reduce the space available to picking, Annie and Aisha both deliberately limited their free time when getting up and washed in the morning.

Two alternative explanations were given for the relationship between boredom and picking. The first is that rather than seeing boredom as a lack of activity, it might be experienced as a positively uncomfortable emotional experience. Picking could be seen as a response to or avoidance of this discomfort, similar to how picking may give relief from stress or overwhelm (see overarching theme '*Switching Everything Else Off'*). Aisha was the only participant seeming to make this connection by talking about how she felt that the 'zoning out' quality of picking (see theme '*Zoning Out'*) alleviates her boredom.

Secondly, the character of the setting of boredom may play a role. Olivia talked about how for her a lack of activity often meant being alone, which meant she became more '*self-focussed'*, which increased her picking. Similarly, Melanie described picking in the shower because she could '*get longer to do it uninterrupted'*, suggesting that time and privacy gave space to the focus of picking. These experiences suggest that some of the processes and behaviours involved in picking, such as intense focus and self-directed attention, may be more present or allowed more space when in private.

Switching Everything Else Off

This overarching theme combines descriptions of the dissociative qualities of picking with the emotional context of picking, showing that the experience of 'zoning out' offered participants relief from emotional and mental noise. The first theme in this section, *'Zoning In to Zone Out'*, explores participants' descriptions of their attention during picking, including intense attention on the act of picking and reduced peripheral awareness. The second theme, '*It Comes with Negative Emotions'*, introduces how many participants noticed patterns in their picking relating to contextual stress and distress. The third theme, *'Reducing Emotional and Mental Noise'* draws the previous two themes together using participants' sensemaking to describe how the attentional experience of picking offered emotional and mental relief. This shows how for many, the attentional experience of SP seems to be a crucial part of descriptions of SP's role in emotion regulation and coping. It also suggests that this attentional experience and escape may make picking more difficult to stop, both because of the respite it offered and the disconnect that it gave from other thoughts, such as those about stopping.

Zoning In to Zone Out

A little over half of all participants described episodes of picking characterised by an intense focus on the immediate process of picking. Participants used language such as '*entranced'* (Annie), '*entirely absorbed'* (Ellen), '*sole focus'* (Jenny) and '*pure focus'* (Marcus) to describe how picking held their entire attention to the exclusion of other sensory information and thoughts. Several participants described picking as being a '*distraction'* (Olivia, Sky, Jeff), which again implies that picking actively consumes and diverts attention. Melanie described how all else was put on hold for focus on picking: '*in that moment in time nothing else matters apart from what your picking and where your picking'.*

In the current study, zoning out was mentioned by all but four participants when explaining how they felt while picking. Of those who did not mention nor imply zoning out while picking, two had arguably more automatic picking presentations (Jeff and Rebecca), and another described their picking as being largely if not wholly motivated by disgust at their skin (Sam). In the current study, all participants who described zoning in on their picking also described correspondingly zoning out from other experiences. Lisa, who had a background of lengthy sessions of focussed picking, explained how her focus on picking occupied her full attention so that all else seemed to stop:

> *I feel like I'm just switching everything else off… it's all about the picking when I'm picking, it's not about anything else… it's blocking everything out for a minute. It's like putting the pause button on almost, stopping the world.*

Zoning out was also described by a few participants who had not described zoning in. It is not possible to tell conclusively from their interviews whether their having not mentioned zoning in reflects their experience, their introspection or that they were simply not asked to expand on their experience of zoning out. Nonetheless, some participants' words suggested that they were more *generally* disconnected, rather than peripherally disconnected while focussed on picking. Sky, for example, noticed that '*it's almost like I'm numb, like I'm sort of void of any thoughts or feelings…'*, her use of 'any' suggesting a more complete disconnect. However, several participants who *did* describe zoning in also described the trance state as being *without* thought, suggesting that picking may consume attention thoughtlessly, as if their focus on picking were a mechanical or behavioural '*autopilot'* (Jenny) process.

Zoning out was characterised by losing touch with senses or external awareness, particularly of time, pain and damage. Julie described how '*there can be trance-like times when I lose track of time picking at my head'* and Annie described '*rarely [feeling] any sort of pain'* while picking. Zoning out was sometimes more implicit in accounts of suddenly realising the reality of damage or time when stepping back from picking. Aisha described her disconnect in contrast with this later realisation:

> *I can sort of zone out of it and I don't kind of realise how long I've been doing it for, and then, I don't know what it is, something will kind of go off and I'll realise what I've done and I'll see the redness and the sort of, the blood an things like that, and then I'll be like 'crap what've I done'.*

This lack of sensory awareness was sometimes indicative of depersonalization, where participants saw their skin as not being part of themselves. Ellen talked about forgetting '*that what I'm doing is attached to my actual face'*, elsewhere describing her skin in disembodied terms as a '*canvas'*, and Lisa said that her skin '*may as well be something lying next to me'*.

Disconnect varied across participants and some described being conscious of thoughts about stopping picking. As presented in the first overarching theme, *'The Voice that Permits Picking'*, the tension between these thoughts and the drive to pick was sometimes described in terms of conflict; Marcus described having '*running arguments'* with himself and Olivia talked about an internal '*battle'*. The two sides of this conflict map onto the distinction between more immediate drives (e.g. wanting to remove texture or the satisfaction of picking) and longer-term wishes (e.g. not wanting skin damage or wanting skin to heal). Leanne described this conflict between immediate and longer-term wants:

> *it's like one bit of my brain is saying "look at the damage you're doing, this is going to look horrible and be painful and take ages to heal, stop it now", and another bit of my brain is saying "but you can't leave it like that, it will drive you nuts, just get that last little bit and then you can relax". And of course that's the bit that wins, and it's never just that last little bit because that last little bit leaves another little bit and then another and another.*

As in Leanne's quotation above, thoughts about stopping were often outcompeted by the drive to pick. Eden described *knowing* that she is causing damage but struggling to translate this awareness into physical action: '*During [picking], I quite often realise I'm doing it and will tell myself to stop but won't physically be able to snap myself out of it'.* This quotation illustrates a subtle trend in language use throughout the interviews that hint towards different characters of the will to pick and the will to stop; the will to pick tended to be described in visceral, felt terms such as urge, want, craving or need. Meanwhile, the will to *resist* picking seemed to have little emotional or visceral content. When giving words to their internal conflict, it was common for participants to talk about *telling* themselves to stop rather than saying that they *wanted* to stop. This hints that those thoughts may be felt as a more deliberate and cerebral representation of what they *should* do rather than being of deeper personal or emotional motivation.

Discussion of attention is complicated by subtleties and contradictions within participants' descriptions. This is captured in Ellen's portrayal of being '*entirely absorbed on one level, klaxons going off on another*', where she describes a sense of absolute absorption alongside some awareness of negative consequences. This feels akin to Melanie's description of having '*two minds*' to describe how both sides can feel absolutely convicted. Discussion is further complicated by participants' apparent movement through different states of thought-consciousness and attention over time. For example, several participants described their awareness of pain or picking consequences gradually gaining prominence in their minds. Lisa, who talks about picking completely '*stopping the world'*, described her gradually increasing consciousness until she stopped picking as being '*like landing a plane',* which I read as implying a gradual descent back toward her senses. Consciousness, thoughts and awareness during picking did not appear to be a simple nor singular experience, both between and within individuals.

It Comes with Negative Emotions

All but one participant described their picking as being sometimes or often preceded by uncomfortable emotions (distinct from tensions relating to abstaining from picking). The emotions described were most often those that carried a nervous energy, such as feeling stressed, anxious, worried, tense, wound up, nervous and upset. These emotions were often felt to increase the frequency and/or aggression of picking, as described by Rebecca:

> *Usually it comes with negative emotions. Stress, annoyed, worried, upset. That's when it gets worse. I can destroy my fingers in a mood like that. If I'm in that mood, I can do it without even being conscious about it till I've made my self bleed and I have to deal with that.*

Around half of those interviewed considered or suspected picking to be at least in part a symptom, response or adaptation to deeper or broader emotional issues and life events. Several participants connected their picking to traumatic experiences, both in formative years and as adults, such as bullying, loss, relational distress and abuse. Lucy considered her picking when at its worst to have been '*a symptom of the distress, despair and utter hopelessness*' that she felt when subject to an abusive and manipulative relationship. Leanne suspected her picking to relate to the traumatic loss of her sibling, wondering whether picking was an '*outlet*' for the more '*deep-rooted*' emotional impact of this suffering, suspecting that it was '*a symptom of that anxiety, the restlessness, the feeling of never being truly peaceful*'.

Several further participants related picking to more general difficulties in managing stress. Some considered themselves particularly sensitive to stress ('*maybe if I wasn't a stress head I wouldn't pick so much!*', Jenny), and others described their current or past lifestyle as exposing them to testing levels of stress. There were suggestions that positive systemic change (such as changes in relationships) or being better able to manage stress had helped to reduce picking. For example, Helen considered that '*learning how to deal with [a period of multiple traumas] has probably helped'*. However, several participants noted that their picking had continued despite positive change. For some, picking became a problem *'in its own right'* (Marcus) with participants feeling '*left with more of a habit'* (Helen) that had been sustained for *'so long it might never break'* (Sky).

Participants gave several explanations for the relationship between emotion and picking. Jeff felt that he noticed more picking targets when stressed as he touched his skin more, rubbing his skin '*as a way of trying to stay calm*'. A couple of participants also suggested that their mood and level of self-criticism impacted how they saw their skin and whether they considered imperfections acceptable; Aisha described how she felt that '*one day I can be like 'oh no it's fine' and the next day it can be the exactly the same and I'm like 'no, that has got to change''*.

Annie described a cycle of picking whereby distress following picking precipitated further picking, explaining that after picking she would feel *'guilty and worse that you did it to yourself… which makes you feel like picking!'*. Marcus also described how distress at debilitating damage causes further picking: *'[picking damage limits my work and makes me] feel a burden, waste of space and it perpetuates the cycle all over again'*.

By far the most common made connection between emotion and picking (though less so among those with a more automatic styles of picking) was that picking served an emotional function, or at least had attractive emotional qualities. Participants described picking as a '*reliever'* (Sky), *'intellectual defence'* (Marcus), *'stress reliever'* (Lucy, Leanne) and as '*therapeutic'* (Jenny). This apparent emotional function is discussed below in the theme '*Reducing Emotional and Mental Noise'*.

While emotional context was significant for many, Eden was explicit in stating that she did not notice emotional patterns and felt that her picking was '*probably more habitual'*. Others were also keen to clarify that reaction to emotional context alone was far from sufficient explanation for their picking. Many participants described still picking *'when I'm fine'* (Melanie), and descriptions of habitual picking and picking when bored, within a routine or throughout the day suggest some picking to take place without emotional impetus, or without awareness of emotional impetus. Several participants who had described picking in response to emotion also considered their picking to exist separately as '*its own entity'* (Lisa).

Reducing Emotional and Mental Noise

The most common explanation for picking's emotional context was that the trance state of picking gave welcome '*distraction'* (Sky, Olivia, Jeff) or respite from other thoughts and feelings. Lucy, who considered her picking to be a stimming behaviour (patterns of repetitive, purposeless movements) associated with her diagnosis of autism, explained how her picking reduced overwhelm when she felt overstimulated and stressed:

> *When I'm in an environment with bright lights and lots of people talking (and this gets amplified greatly by stress and/or tiredness) – everything is just too much and I guess the stimming (which the biting/picking is part of) redirects my attention onto something I can handle when I can't handle the world around me*.

Marcus vividly describes the calming effect of a singular focus on picking:

> *My thought process becomes like a carousel at the fair, blurred images whizzing past my eyes unable to pick a thought and hold it down long enough to process it. Then in the madness the only thing that quietens the mayhem is picking. The act of picking focuses my mind in a singular thought and task, giving my brain a much needed break from itself…*

Participants talked about how the process of zoning out helped them to '*forget'* (Helen, Jenny) about '*day to day things'* (Helen) and *'whatever else is going on'* (Jenny). Annie said that it helped her to *'calm and clear my mind'* and Sky described how the absence of thoughts and feelings meant that she could '*take a break from life'*.

While most descriptions implied that picking gave distraction from thoughts, Lisa painted a more complex picture. She explained that her picking put everything *'on pause for a bit… allowing myself to stop and think for a minute*', suggesting that her picking gave her space to engage with her thoughts in a different way. She seemed to describe picking as giving her distance and detachment from her thoughts, allowed her to better process them:

> *I still do feel that I have this kind of innate need to just come away and just, let everything kind of settle. That process, with my mind almost like observing in the background and just let the experiences of the day just sort of filter through, and then feeling OK about everything again and that I can get on with the next bit now. The picking has just sort of become part of that.*

The idea that picking might help to process thoughts was also implied by a couple of others, such as in Ellen's description of defaulting to picking when '*working through a problem'*

The experience offered by picking meant that while it was a largely unwanted behaviour, a few participants considered it to have been at times '*a helper'* (Lisa). Around a third of participants described picking as having a role in coping, either reluctantly conceding that picking may have helped them or being more positively embracing of it. All participants who described picking as helpful recognised the tension between this benefit and picking's more distressing qualities, as Aisha explained:

> *[After picking I think] 'what have you done', 'you look horrible', you know like 'you've made it worse' things like that. And then there's the flip side of 'it helped be out of what I needed to be out of at the time'.*

Marcus similarly valued the emotional function of his picking, saying that *'…picking is my release.... if anything [life without it would be] worse*'. Several participants considered picking to be preferable to more harmful alternatives, such as self-harm and smoking. Leanne felt that her picking *'could just as easily manifest itself if some other way'* and Annie clearly presented how she felt picking to be interchangeable with other methods of coping:

> *I think everyone has something so you can fill in the blanks! I've just got home from a horrific day at work and the first thing I do when I get home is....*
> *- pour a glass of wine*

> *- go for a run*
>
> *- put the kettle on and scoff 4 biscuits*
>
> *- light up a joint*
>
> *My answer would be roll up my sleeves and scan my skin for bumps to pick…*

Some participants described picking as an opportunity to unwind, describing picking as soothing, comforting and as helping them to relax. Jenny described her routine of picking after her son's bedtime as '*my time to chill out'* and Aisha similarly talked about picking during '*time for me'*. Lisa considered picking to give refuge from the day's demands and feelings, allowing her to '*just be on my own and control what I'm feeling'*.

I Worry About People Looking and Judging Me: Distress in How Picking is Seen

While the direct consequences of picking were distressing to many (such as pain and loss of time; see '*Introduction to the Interviews'*), distress mediated by the appearance or interpretation of picking and its damage was powerful across the interviews. The first theme in this section, '*Shame of Picking'*, describes participants' self-consciousness of their picking and the damage that it caused. The second theme, *'I am Misunderstood'*, considers participants' distress and frustrations with feeling misunderstood, and how this impacted on speaking about picking and help-seeking.

Shame of Picking

Helen said that her picking '*makes me hate me and the way I look*'. Such distress related to the *appearance* of picking damage and picking behaviour was present to varying degrees across all interviews. Concerns about appearance were often of a social nature and were evident in explicit accounts of shame, self-consciousness, embarrassment and concerns about other people's thoughts or judgement. Concerns were sometimes more implicit, such as in participants' efforts to conceal damage or self-consciousness about others noticing damaged skin. For some, the appearance of visible damage was their primary if not only concern. Ellen felt that all her concerns related to the visibility of skin damage:

> *If it didn't leave a mark I genuinely wouldn't care in the slightest… I realise more and more that there is no normal and everyone has 'something' that they deal with. I'd prefer that my 'something' didn't leave physical marks.*

It was not clear from Ellen's description whether her regret at the marks related to whether she felt them to be a problem in their own right or whether they revealed her underlying 'something', which I read as meaning an underlying psychological issue or struggle.

Some participants used methods of concealment such as makeup and strategic clothing, and some described avoiding activities or occasions that necessitated skin exposure or makeup removal. Situations where this avoidance of exposure was not possible caused anxiety; Melanie worried about an upcoming holiday because she felt that her scars and sores might attract unwelcome attention and be '*stared at'.* This fear of others noticing picking damage impacted social activity and relationships. Eden described avoiding eye contact with her partner when not wearing makeup and Helen talked about complete social avoidance after picking:

> *If I've had a bad pick I will cancel plans and avoid anyone seeing me, I won't even answer the door. If I do have to go out my anxiety is through the roof… [I worry about] people looking and judging me… wondering what is wrong with me.*

It was not always clear as to whether shame focussed on the aesthetic appearance of the damage or on the picking behind the damage. Aesthetic appearance was clearly important for some, with several participants saying that their picking made them feel or look unattractive. Melanie pointed out how rarely unclear or scarred skin was represented in the media, implying that it was not attractive or acceptable by '*social media and society standards'*. Several others feared that skin damage would be mistaken for *'something wrong'* (Annie), a '*bad rash'* (Sam), an '*infection'* (Sam, Rebecca) or '*some weird disease'* (Jenny), and Annie felt the need to reassure people that it was not '*contagious'*. Others worried about or had negative experiences of people mistaking their skin damage for deliberate self-harm or acne.

For some, the problem with the damage was that it revealed the act of picking. All participants talked about hiding the act of picking to some extent. Jenny called it a '*dirty little secret*' and Leanne joked that she '*wouldn't do it in public anymore than I'd go to the toilet in front of a complete stranger*'. Lucy considered this hiding to relate to picking being considered *'a habit that society sees as disgusting'*. Melanie described her distress that scars proved a permanent reminder of *'what you've done'*. Rebecca and Jeff both described making '*excuses'* (Rebecca) for damage by saying that they'd cut themselves, and Julie described avoiding medical treatment for her wounds as '*it's really hard to try to explain how self-inflicted wounds have happened'.* These accounts suggest that the damage would be less shameful or more acceptable were it caused by accidental means. Leanne made this point explicitly:

> *It's not something that has happened to me by accident that was out of my control, I wouldn't be ashamed then, so it's got to be that it's something I've physically done to myself and I'm ashamed that I haven't been in control of myself enough to not do it.*

While feelings of disgust and shame in the act of picking were powerful, most participants did not articulate specific cognitions relating to their feelings. This may relate to ideas from cognitive psychology that propose that social cognition, and behaviour in response to it, may have roots in previous experience that is unavailable to self-report or introspection (Greenwald & Banajii, 1995). However, some participants did identify cognitions that picking was '*childish'* (Lucy, Sky) or that it reflected poorly on their ability to present or look after themselves.

Some participants, similarly to that described in Leanne's indented quote above, described shame in feeling out of control. When asked why she'd worry about talking to others about her picking, Lisa's concerns were that others would think '*that I don't have self-control. And that I'm disgusting… they would think, 'why are you doing that disgusting thing''.* As well as being described as a source of shame, loss of self-control was a source of guilt, anger and sadness. These painful feelings often centred on the idea that they had somehow *'failed'* (Eden, Leanne, Sky) themselves by picking despite knowing the damage it causes. Olivia was particularly frustrated by how she ‘could’ stop but that she did not:

> *You think you’re in control and then you’re not. And I feel really bad about not having that self-control… I could stop anytime but something, something doesn’t. And this part that I don’t seem to have control over, that’s what’s troubling me.*

Participants’ shame, embarrassment and disgust sometimes seemed impacted by social interactions, such as when others misunderstood picking (see ‘*I am Misunderstood’*) or had been abusive and bullying. Participants were also self-conscious in the absence of an explicit response from the other; Ellen described closely watching faces to see ‘*what’s unsaid’* and Helen called picking the *‘elephant in the room’*, implying that she felt silently conscious of her skin being noticed.

A couple of participants considered their shame to be mediated by projections of their own internal thoughts and be ‘*more my own reflections’* (Olivia), suggesting that for some, self-consciousness came from skewed interpretations of others’ thoughts. Annie considered this to have been true of her distress, describing how her shame eased when she found others to be accepting:

> *…once it’d been said it became not as a big a deal if I had picked and it was on show because I didn’t feel worried that they’d be like ‘urgh what is that’. And I learned that most people don’t think of it as big of a deal as me… they’d barely even notice what I would fixate on.*

I am Misunderstood

Many participants felt that their picking was misunderstood as being easy to stop, frequently expressing frustration that others advised them to ‘just’ stop picking. In the current study, Jeff explained that he found comments about stopping shaming as it was *‘like it’s something I should be able to control and is easy for me to stop doing’,* suggesting that continuing to pick was seen to reflect a weak will. Several participants expressed frustration that picking was seen by others as a bad '*habit'* (Annie, Rebecca, Olivia), a word seen to diminish the complexity and tenacity of picking, undermining the depth or difficulty of their experience.

Many participants described a reluctance to seek professional help or support, and those who had sought help in the past described being met with varied receptions. Some told positive stories of professionals recognising their distress and working to understand them, while others had experienced medical professionals as '*less than interested'* (Ellen) or dismissive. Jenny described how a psychiatrist failed to account for her subjective experience of picking and distress:

> *I saw a psychiatrist and when I mentioned it to him and showed my legs to him he pretty just ignored what I said and started talking about something else! … it was annoying because to me it is a problem, yet he just made it seem like it was just nothing… I'd just like them to take it seriously, rather than making me feel like I'm just being silly and it's not a problem at all.*

It was common for participants to feel that, if they were to seek professional help, the professional should have a pre-existing understanding of picking. Ellen stipulated that any future therapist have '*a firm understanding that it is a real 'thing''* and others felt similarly, seemingly because they felt it would help them *'to be understood'* (Olivia) and that their SP would be treated *'as a serious issue'* (Leanne). It was considered that this would help treatment *('I wouldn't know what would help me stop it so I'd need someone that had experience in it'*, Sky) and reduce shame.

Feeling misunderstood was often silencing. Several participants described a reluctance to talk about picking fearing that others would form negative judgements, or they felt that *'it's just more hassle than it's worth'* (Rebecca) because others would not understand. Conversely, many participants expressed a sense of freedom and relief where they did feel understood. Participants were largely recruited from online support forums, and Sky was among several who described how these spaces gave recognition and solidarity:

> *When I found the Facebook group, it felt like suddenly I wasn't alone in this. My boyfriend tries to understand but he's never understood that it's a compulsion, so it was such a relief to see other people that have a similar problem.*

Participants in the current study also described relief in being able to talk openly in the interviews. Sam described how the interview's non-judgemental manner had given her confidence to ask for support from her partner:

> *It's actually been really nice [to be interviewed]. I was worried how comfortable I'd find it but it's been very relieving to talk to someone about it that doesn't have any opinions or advice to give, as well intentioned as it may be. It's actually given me the confidence to tell my boyfriend that I'm fine with him gently touching my hand to stop me but nothing else more forceful, and that I need his support to try and stop.*

Sam's experience appears to show that value of an accepting relationship in dispelling shame, and suggest transferability of this confidence into other relationships. This suggests the importance of acceptance and understanding within therapeutic relationships.

Participants frequently described how they had also found a sense of solidarity and recognition in picking being labelled as a distinct condition or diagnosis. Several participants described SP's distinct psychological labelling as making picking '*actually a condition… this is a thing'* (Aisha) and a *'real disorder'* (Sam) as compared to how they or others had previously seen it, often as a '*bad habit'* (Rebecca, Annie). This suggests that psychological labelling was experienced as validating the complex experience of picking and the struggle to stop, suggesting that unlabelled or habit-related distress was not taken seriously or considered 'real'. For several participants, the objective identification of picking also gave relief from alienation by implying that *'other people did it too'* (Annie). Distinct psychological labelling also seemed to take some responsibility for picking away from participants. Helen commented that understanding SP to be a 'condition' showed that *'it's something I'm not doing on purpose'* and Sam expressed relief at being told *'it's a disorder, you can't* *help it'*. Sky felt comforted by the idea that it '*genuinely isn't something you can always control',* implying that seeing picking as a condition alleviated her worries that picking reflected poor motivation or self-control. While this acknowledgement of participants' struggle against their drive to pick gives recognition to their experience, there is a risk that it could undermine agency and hope for positive change.

Participant Reflections on Interview Modality

Towards the end of their interviews, participants were asked to reflect on the rationale for their choice of interview modality and on their experience of the interview. Their responses gave insight useful for future research and are summarised below.

Practicalities and Participant Convenience

The ability to integrate the interview into daily life was an important determinant of interview choice. For several participants this was more possible with an asynchronous interview modality, such as IM or email, as '*you can pick up and leave off around whatever else you're doing'* (Annie, *WhatsApp*) making it '*more convenient'* (Jeff, email). There were concerns that synchronous modalities that required a defined period of time were impractical, and several participants considered that they '*wouldn't have the time'* (Melanie, *Facebook Messenger*) or childcare to attend. However, asynchronous modalities were not always considered more convenient; Aisha felt that it would be '*easier and quicker'* to conduct her interview over the telephone as she might be distracted on IM or email platforms.

Social Comfort and Confidence

Many participants described choosing their interview modality by level of social interaction, revealing the impact of the researcher's presence as a social object. Almost every participant who chose an IM modality in some way described finding it '*easier to talk about personal things'* (Jenny, *WhatsApp*) over IM. It was common for participants to say that they '*hate'* (Sam, *WhatsApp*) using the phone or *Skype*, and that it would have limited their participation or prevented them from participating altogether. Some found that IM modalities put them at ease and felt '*like talking to a friend'* (Annie, *WhatsApp*) and was '*just like having an ol' chat'* (Marcus, *WhatsApp*).

Leanne considered *WhatsApp* to be a more '*anonymous'* modality, and Marcus (*WhatsApp*) felt more comfortable with disclosure given the researcher distance: *'I don't trust people generally… I know I am trusting you with a lot of information but you are online/distant, legally bound and seem nice*'. Several participants felt that a more socially exposing interface would mean that they were distracted by '*the social aspects'* (Lucy, *WhatsApp*). Rebecca (*WhatsApp*) described how this would limit her responses: *'[being interviewed via WhatsApp is] fine, because I'm talking to my phone really. I'm not seeing your face… [face to face] I'd be awkward and shy. Probably wouldn't tell you much lol'*.

Some participants identified visibility as being particularly off-putting given the relevance of their skin to the interview. Ellen (*WhatsApp*) described how she feels '*super defensive about my skin'* and how being seen would make her feel open to the interviewer's judgement, imagining that the interviewer would not '*be able to resist having a good look at [my skin]*'. Helen (*Facebook Messenger*) described how skin damage would make her self-conscious to the point of avoiding the interview: *'[this interview is less awkward] because you can't see me… If I had a bad picking session I would avoid you [if you could see me].'* However, self-consciousness did not necessarily mean that participants chose a more distant modality; Lisa (*Skype*) felt that being able to see the interviewer's body language and responses would reassure her, as otherwise her *'head will play little games and I'll maybe make some negative conclusions about what they're thinking or doing'*.

Thinking Space

Participants who chose asynchronous modalities frequently described preferring the '*thinking space*' (Ellen, *WhatsApp*) that it allowed them. It allowed them to answer '*at my own pace'* (Marcus, *WhatsApp*) and '*really think about my response'* (Eden, *WhatsApp*), suggesting that participants felt in control of the pace of the interview. Some participants felt that thinking time improved the quality of their answers, such as for '*emotive issues [where] it's hard to get your words out right'* (Annie, *WhatsApp*). Sam (*WhatsApp*) said that a synchronous modality would have '*just gotten rambles from me'*, suggesting that asynchronous modalities allowed her to more clearly order and present her thoughts. Conversely, Lisa (*Skype*) found thinking space to be problematic as she could '*get very hung up about what I'm writing sometimes'* and might have '*overthought*'.

Discussion

The current study considers three dimensions of the problematic experience of SP, spanning the drive to pick, the experience of picking and the consequences of picking. As well as offering insight into the lived experience of individuals with SP, an understanding of the mechanisms and meanings of these experiences may help to guide therapeutic intervention and support.

Overarching theme '*The Voice that Permits Picking'* gives words to the patterns of thoughts and attention that many participants identified as driving their picking or weakening their resistance, as well as the environmental factors (e.g. being alone, sedentary activity) that best permitted picking. Possible avenues of therapeutic intervention to target these triggering cognitions and circumstances are discussed below under '*The Circumstances and Thoughts that Drive Picking'*.

Overarching theme *'Switching Everything Else Off'* explores how the attentional experience of picking offers an appealing escape from stress and overwhelm. This locates possible problems in contextual emotion and mental overwhelm (suggesting that contextual emotion or systemic factors that induce overwhelm may be targeted by therapy), and/or in picking's use as a problematic coping mechanism (suggesting that it may be helpful for therapy to strengthen alternative coping strategies). While the apparent emotional function of SP for many has been previously suggested (Flessner & Woods, 2006), the processes by which picking offers relief have not to my knowledge been explored in depth. Participants in the current study give rich descriptions of the mechanisms of this experience, which may be helpful for therapists to understand when developing alternative coping strategies that meet the same need and offer similar relief. This discussion may also have transdiagnostic application, discussed below under '*Attention as a Mechanism of Relief*'.

Overarching theme '*I Worry About People Looking and Judging Me'* highlights shame and the eyes of others as often being definitive of regret and distress following picking. Considering this experience alongside the previous overarching themes, this distress may drive further picking by increasing self-criticism and strengthening permission giving cognitions (see '*The Voice that Permits Picking*'), as well as increasing the alure and grip of a zoned-out headspace (see '*Switching*

Everything Else Off'). The social avoidance relating to shame may also, as well as by itself impacting on quality of life, increase factors such as aloneness or boredom that may precipitate or accommodate picking (see '*Picking Because I Can'*). Distress that occurs as a result of SP, such as this shame in damage caused, has received very little discussion in research or treatment suggestions to date. This distress and its therapeutic significance are discussed below under *'The Centrality of Distress in the Problem of Picking'.*

The cognitions, attention and distress of SP described in the current study bears striking similarities with those presented by Rehm et al. (2015) in their detailed Interpretive Phenomenological Analysis of hair pulling. Rehm et al. (2015) developed six superordinate themes of beliefs spanning negative self-beliefs (including that the self was worthless or abnormal), control beliefs (including the importance of control and the loss of control while pulling), beliefs about coping (including having limited coping strategies and used of pulling to cut off from life), beliefs about negative emotions, permission-giving beliefs (including justification of pulling and the reward of pulling), and perfectionism. These similarities support the idea that the two experiences may share characteristics transdiagnostically (Snorrason et al., 2012).

The Circumstances and Thoughts that Drive Picking

Overarching theme '*The Voice that Permits Picking'* discusses apparent patterns in the cognitions that drive picking and undermine resistance, leading individuals to pick to the point of skin damage and lost time, and causing distress and feelings of loss of control. It seems imperative that therapists are prepared and equipped to support individuals to understand and manage their immediate drive to pick. This drive to pick has been the central target for previously suggested therapies such as HRT, CBT and ACT (e.g. Schuck et al., 2011; Twohig et al., 2006), which have between them aimed to recondition, restructure or promote acceptance of the impetus to pick. Despite several studies considering the application of these approaches, little attention has been paid to the nature of the cognitions or behaviours that they target, with the exception of individual-focussed case reports (e.g. Deckersbach et al., 2002).

Findings from the current study suggest patterns and themes in cognitions that drove picking or weakened resistance. While cognitions such as the want to improve texture (e.g. Arnold et al., 1998; Deckersbach et al., 2002) and preoccupation with picking targets (Grant et al., 2006) have been described in previous research, the current study's qualitative approach allowed these experiences to be discussed in richer detail and with participant voices and sensemaking at the forefront. Permission-giving cognitions identified by participants (paraphrased) were that 'texture is unacceptable', 'I need to pick it all', 'it's going to happen eventually' and that 'the damage doesn't matter' (either 'it won't be seen'/'it can be hidden'/'I didn't like my body anyway').

The drive to 'pick it all' and appeal of completion, mentioned by some participants, has had minimal discussion in past research, and seems related to the idea that incompleteness may be uncomfortable for people who struggle with SP (Snorrason, 2016). The preoccupation that many participants described if unable to achieve this completion is evocative of the 'Zeigarnik effect' (see Zeigarnik, 1938), whereby interrupted or incomplete tasks persist in memory. James and Kendell's (1997) discussion of this effect describes how the felt need for closure may be particularly powerful in compulsive conditions where individuals may feel particularly responsible and be driven to act. However, participants' experience of a 'rush' when picking and sense of it being intrinsically rewarding (as opposed to being a compulsive behaviour to dispel a negative) corresponds with the pleasure and gratification described in hair pulling (Rehm et al., 2015) and the idea that it is pursued as an 'end in itself' (Christenson et al., 1991). Participants' words such as 'craving' connected SP to the impulsivity of addictions, as has been considered in previous research (Odlaug & Grant, 2010). These multiplicities in the experience of SP suggest that it may be difficult to tease apart impulsive and compulsive characteristics.

As well as identifying these cognitions, many participants described how these thoughts seemed influenced by factors such as social experiences, attention, sensory information, how much the body or self was valued, self-focus, inoccupation or the ability to conceal damage. For example, participants of the current study suggested cognitions to remove skin texture had roots in negative appraisals from others, corresponding with Rosen et al.'s (1995) assertion that negative attention from others in adolescence leads to internalised assumptions about 'normal' appearance, with implications for self-worth and acceptance. Therapeutic interventions targeting cognitions and schemas about the bodily self-image are discussed below under *'The Centrality of Distress in the Problem of Picking'.*

Attention to skin and intense self-focus also appeared to precipitate cognitions to remove texture. Participants described intense focus on small details similar to that reported by the subject of Deckersbach et al.'s (2003) case report, who described "zooming in on these spots on my face" (p. 255), and seems similar to that described in other body-focussed distress, such as body dysmorphia (Clerkin & Teachman, 2008). Previous research has established that mirror gazing, particularly close-up, has an impact on body image and urges to change appearance (Barnier & Collison, 2019), suggesting that intense self-attention might increase the urge to pick.

An understanding of these precipitants may be particularly helpful for therapists developing interventions seeking to sensitively reduce picking behaviour. For example, circumstances seemed to impact picking behaviours, with several participants describing how they gravitated towards picking where they had free time, were bored and/or alone. The idea that picking is more likely when the hands are free and less likely when busy relates to previous research into 'habit disorders' (including scratching the skin) that notes increased habit behaviours during times of relative passivity or waiting, and speculates that this relates to hands being unoccupied (O'Connor et al., 2003). The tendency of participants to pick when alone corresponds with research that suggests that picking tends to occur in private (Bohne et al., 2002) and in situations of reduced socialisation (O'Connor et al., 2003), and that visibility to others seems to inhibit picking (see discussion under theme *''Oh Well' and 'So What?''*). This discretion seems understandable in the context of the shame associated with picking (Anderson & Clarke, 2019). Alternative connections between aloneness and picking may be that social connection plays a vital role in wellbeing and emotional regulation (e.g. Seppala et al., 2013), and the absence of this source of regulation may secondarily impact picking. Lack of social connection has been proposed to be a factor in substance addiction (Hari, 2015), which may be relevant for other issues involving impulsivity such as SP. Furthermore, research suggests that social exclusion and isolation increase self-defeating behaviours (Twenge & Baumeister, 2005). It would be understandable that, where boredom or a lack of activity occurred alongside social isolation, there may be a relationship with picking via socialisation, visibility and/or self-consciousness. While research has identified boredom as a precipitant of picking (e.g. Bohne et al., 2002), to my knowledge the mechanisms of this relationship have not been explored. In therapy, behavioural interventions that focus on filling time positively or engaging socially at particularly triggering times may be helpful.

Several participants on the current study described how the ability to hide picking seemed to contribute to a cycle of picking because it can be hidden, then hiding because the skin has been picked. This seems to overlap with Rehm et al.’s (2015) qualitative study of hair pulling where they found permission-giving thoughts and justifications to be common, and where one participant described how her ability to conceal bald areas “triggers off the urge” (p. 221). This cycle may be sensitively challenged by goals to stop hiding, such as how in the current study, Annie described challenging herself to reveal her skin when swimming, and as used by Deckersbach et al. (2002) in an individual’s treatment. This may be a useful therapeutic technique, though would need sensitive planning so as not to unhelpfully expose the individual to feelings of shame. Martinson (2011) emphasise the importance of this kind of exposure occurring within a supportive and collaborative therapeutic relationship, and careful appraisal of risk (such as the potential for discrimination at work).

Attention as Mechanism of Relief

Past researchers have considered an emotion-regulation model of SP based on its emotional sequalae (Keuthen et al., 2000; Roberts et al., 2013; Wilhelm et al., 1999). The current study begins to identify the mechanisms by which this occurs, illustrating how the relationship between distress and picking seems mediated by the attentional phenomenology of picking (see ‘*Switching Everything*

Else Off'). It suggests that for many, 'zoning in' or intense focus on the repetitive and satisfying task of picking allows them to zone out away from stresses, competing thoughts and overwhelm. Language used by participants was very similar to that described in Rehm et al.'s (2015) study where participants described hair pulling as "a break from thinking" and said that it "pushes out emotional sensations" (p. 219), suggesting a need for future research to consider a more trans-diagnostic approach when seeking to understand the use of repetitive behaviours for emotional/thought management. It seems to be used by some as a dissociative emotional regulation tool, suggesting a need for treatment to support development of alternative coping that causes less harm and distress to the individual.

The idea of zoning in has not been explicitly discussed within SP research, though it seems to relate to Wilhelm et al.'s (1999) term 'mesmerized', described as a prominent emotional characteristic during picking. It also seems related to Deckersbach et al.'s (2003) description within a case study of "zooming in" (p. 255) in front of the mirror, and may be inherent or implicit in the word 'focussed' (used to describe a style of picking; Walter et al., 2009), though to my knowledge past research has not explicitly captured nor explored the phenomenology of how attention is consumed by the act of picking. The current participants' descriptions seem evocative of Heatherton and Baumeister's (1991) description of 'cognitive narrowing' during binge eating, whereby individuals might escape self-awareness by narrowing "the focus of [their] attention to the present and immediate stimulus environment" (p. 88). Heatherton and Baumeister (1991) apply 'Escape Theory' to binge eating, theorising that a focus on eating behaviour may give relief from unpleasant feelings by avoiding meaningful thought. This theory seems relevant to the idea of a '*trance state'* (Melanie) or disconnect from thoughts, senses and external reality while picking, which has been briefly mentioned in research relevant to SP. For example, Wilhelm et al. (1999) observed a trance-like mental state in SP and Rehm et al.'s (2015) hair pulling study's theme about experiential avoidance described a "trich-trance" and "zoning out" (both p. 219). To my knowledge, this experience in SP has not been explored in depth.

Participants' descriptions of depersonalisation of the skin while picking were evocative of Nadelson's (1978) description of imperfect skin being felt as separate from the self in those suffering from skin disease. Viewing of the self as an aesthetic object as opposed to living subject has been described by research into body dysmorphia, and Veale (2004) considered that attention may be so consumed by this object image that there is little focus on other bodily senses. As issues of time spent picking, pain and skin damage all require awareness of sensory information and were considerable components of picking distress (see '*Introduction to the Interviews'*), disconnect from these experiences seems likely to detract from the will to stop. This means that the attentional experience of picking may perpetuate further picking via weakened resistance. Heatherton and Baumeister (1991) consider that, where self-awareness is reduced by focus on a problematic behaviour (specifically considering binge eating as a problematic behaviour), the attentional experience "deconstructs the troublesome meanings of such acts, thereby removing intrapsychic obstacles and making the person more willing to commit them" (p. 89).

The analysis demonstrates the complexity and multiplicity of attention during picking. While previous research has described picking attention and awareness in simple terms, such as that focussed (or compulsive) picking generally involves being conscious of an urge to pick and automatic (or impulsive) picking occurs without awareness (Arnold et al., 1998; Walther et al., 2009), the descriptions in the current study involve more grey and changeable areas. Even where firm statements were made about zoning out during picking, these were often suggested to relate to one '*level'* (Ellen) of the psyche, implying that some consciousness of an alternative level or levels of attention. Further exploration of this area might give insight into the relationship between attention and self-regulation. It may be interesting to consider SP attention in the light of research into mind wandering and attention, where behaviours become 'autopilot' and attention is decoupled from sensory information in the external world (e.g. Schooler et al., 2011). As with SP, mind wandering increases when individuals are subject to stress and has been suggested to have an adaptive function (Crosswell et al., 2020; Mrazek et al., 2011).

The Centrality of Distress in the Problem of Picking

The current study's analysis highlights the power of distress in the experience of SP, presenting it as both a precipitant and problematic consequence of picking. All but one participant described emotion as increasing or intensifying picking behaviour, and picking had distressing consequences that, for some, appeared to play into further cycles of picking.

Most of those taking part in the current study related their picking to stress, such as that they were particularly sensitive to stress, supporting Snorrason et al.'s (2010) suggestion that picking may relate to higher emotional reactivity, or that stressful circumstances precipitated picking. Previous research has shown that stress impacts the prioritisation of instinctive processes, reducing executive thought and increasing risky decision making (Starcke & Brand, 2012). Similarly, stress has been shown to correlate with issues of impulse control, including SP alongside issues such as problematic internet use and compulsive shopping (Leppink et al., 2016). Leppink et al. (2016) considered that this relationship could indicate that impulsive behaviours have an emotion regulatory function, or conversely that the presence of impulsive behaviours caused stress.

Participants explanations for the relationship between stress and picking included that stress increased touching of the skin (in keeping with research suggesting displacement behaviours may moderate stress (Mohiyeddini & Semple, 2013)) and/or impacted self-criticism. Research into body dissatisfaction has shown that mood impacts how the self is seen, such as that sadness significantly increases self-attention paid to individuals' body concerns (Allen et al., 2018). Participants in the current study also described cycles of picking and distress, corresponding with the view that the relationship between mood and assessment of the skin may be complex and perhaps reciprocal (Anderson & Clarke, 2019).

Theme '*Reducing Emotional and Mental Noise'* presents vivid descriptions of picking being used as a calming, distracting, regulatory behaviour in times of overstimulation and to manage traumatic experiences and memory (see below for a discussion of trauma and SP). This perspective echoes the stimulus regulation model of hair pulling, whereby hair pulling is considered an attempt to balance senses and levels of stress (Penzel, 2003). Similar theories have been proposed to explain repetitive behaviours in autistic people, where stimming is felt to regulate sensory overload and uncontainable emotion (Kapp, et. al., 2019). A participant in Kapp et al.'s (2019) study of autistic adults reported how the single point of focus in rhythmical stimming helps regulation in that it "metronomes everything in your body" (p. 1786). Repetitive and stereotypic movements are also present in neurotypical adults (Castellanos et al., 1996), meaning that this insight may be relevant beyond autistic populations. The current study presents descriptions of picking as regulation by individuals both with a diagnosis of autism and without, presenting striking similarities between the experiences, with both groups describing the singular focus of the behaviour as giving relief. This observation is preliminary and requires further exploration. It may be interesting for further research to explore the phenomenology of relief-driven repetitive behaviour transdiagnostically.

The current study presents some interesting descriptions of the process by which picking seemed to help individuals to process thoughts and feelings. One participant's (Lisa) description of 'observing' her experiences seems similar to the attentional stance adopted in mindfulness practice, whereby experiences and thoughts are observed in the moment as they are, without interpretation (e.g. Shapiro et al., 2006). It also seems similar to the experience described in Capriotti et al.'s (2015) first case report, where the individual "reviewed and "processed" events and emotions" (p. 233) while picking. Previous research considering the mechanism by which activity may help regulate emotion has tended to consider distraction (diverting attention from negative feelings) and venting (immersion in and expression of negative feelings) as distinct (e.g. Genuth & Drake's study of the therapeutic effect of drawing, 2019). The participant's account implies a less binary relationship, suggesting that picking provides the space to more gently be present with feelings and experience, rather than being a complete distraction.

It seems imperative that a therapeutic approach seeking to address the problem of picking should consider distress itself as a target or focus of therapy, paying attention to both distress that may trigger picking, as coping and the distress that may follow picking; a reduction in distress, as well as being a positive outcome in itself, would likely also reduce picking by weakening the mechanisms and cycles that drive or exacerbate it. However, the management of picking-related distress and contextual emotion has received little attention in past research. It seems to have been included as a minor element of CBT protocols; Deckersbach et al (2002) discussed a patient whose therapy, once picking behaviour was under control, was “primarily focused on coping with her life’s stressors” (pp. 367-8), and another whose therapy involved “emotion regulation training” (p. 370). Alongside this, the principles of ACT, an approach suggested to be effective with SP (Flessner et al., 2008a), involves a loosening of the relationship between thoughts and action, and therefore may be a useful tool to target SP related and contextual distress. However, research considering ACT’s application to SP has largely focussed on reducing the tenacity of and encouraging acceptance of the *urge* to pick, rather than addressing the individual’s *distress* before or after picking.

The current study specifically highlights shame as central in many participants’ distress. Shame is a powerful emotion which may have wider psychological and social consequences, such as contributing to hopelessness and depression (Abramson et al., 1989) and feeding into a cycle of social avoidance whereby experiences of social acceptance are limited, thus reinforcing shame (Wells et al., 1995). Shame may be significant in the mechanisms by which distress appears to increase picking; the experience of social prejudice has been shown to diminish self-regulation and self-control (Inzlicht et al., 2006) and therefore may increase impulsive behaviours such as picking.

The current study’s analysis of participants’ shame presents shame focussed on appearance as central in picking distress. This suggests that it may be helpful for therapists to draw from research and interventions concerning appearance anxiety. Clarke et al.’s (2014) guidance on CBT approaches for appearance anxiety considers the role of experience, assumptions and schemas, noting the power of social and appearance-specific cognitions. They recommend applying CBT principles to appearance-related distress and the cycles that maintain it. ACT may also be useful for working with issues relating to visible difference, such as distress from isolation, shame and body image dissatisfaction (Zucchelli et al., 2018) and to increase psychological flexibility (Shepherd et al., 2019).

While considering these individual, internal psychological variables and their role in distress, it is important to acknowledge the significance of direct exposure to episodes of stigmatisation relating to the skin's appearance, such as bullying and prejudice from others (Thompson & Montgomery, 2018). Indeed, as described by one participant (Melanie) in the current study, systemic influences such as cultural beauty norms and the tendency for media to portray clear skin may impact cognitions and feelings about appearance. Exposure to idealized body images such as those in the media has been shown to be detrimental to body image and increase appearance anxiety (Monro & Huon, 2005), and research suggests that "cultural norms and values may influence the content of body dysmorphia symptoms" (Philips & Diaz, 1997, p. 570). Furthermore, cognitions that unclear skin may reflect poor health or be generally unattractive, as described in the current study, correspond with thinking about the evolved origins of stigma as being in part related to pathogen avoidance (e.g. Kurzban & Leary, 2001) and have been related to the experience of living with acne and psoriasis (Kellet & Gilbert, 2001; Hrehorów et al., 2012) as well mental health conditions including SP (Dawydiak et al., 2020). Shame relating to the loss of control corresponds with the idea that loss of control may be seen by others to threaten the evolved need for dyadic cooperation and thus be a source of stigma (Kurzban & Leary, 2001). It seems imperative that therapists acknowledge these systemic factors and their role in contextualising shame and distress.

In the current study, several participants described traumatic experiences or trauma-related distress from which they sought emotional relief (see '*Switching Everything Else Off*'). This corresponds with Özten et al.'s (2015) findings that both SP and hair pulling related to higher instances of traumatic events, and that a longer duration of hair pulling or SP predicted lower rates of post-traumatic stress symptoms. Özten et al. (2015) speculated that this relationship might be explained by the repetitive behaviours helping individuals to cope with intrusive thoughts, an idea supported by some participants of the current study. This theory maps onto the idea that dissociation serves as a protection against the intolerable impact of trauma (Pearlman & Saakvine, 1995). In these cases, therapy to help the processing of past traumas or the management of traumatic stress may be most appropriate. Indeed, therapeutic approaches focussed on reducing picking could be actively harmful where contextual emotion is not acknowledged and responded to; some participants in the current study suggest that a reduction in picking behaviour may remove an essential coping mechanism. Where trauma is happening in the present, therapy that takes a systemic approach towards assisting with the reduction or management of stress may be appropriate. Where trauma appears to have impacted on bodily self-image, such as where bullying has shaped self-critical appraisals of imperfections (see the theme '*Skin Texture Must Go'*), work to reduce the impact of that trauma on the present may be helpful; preliminary research has suggested that 'imagery re-scripting', where distressing self-images from past experience are restructured as benign in the present, may be useful in managing body dysmorphia related to trauma (Willson et al., 2016). Therapists might also consider interventions to grow self-compassion and esteem, as may be useful in body dysmorphia (Sündermann et al, 2016) and skin conditions (Clarke et al, 2020).

The significance of distress, the centrality of shame in this distress and the interpersonal nature of shame, indicate the importance of the therapeutic relationship and the role of the therapist in ameliorating or worsening distress. The current study presents accounts of the impact of dismissive professionals and how disregard for distress may be shaming and silencing. This echoes Kellett's (2002) discussion of dermatological shame, where they note the importance of a clinician's empathy to distress and consider that a dismissive approach risks increasing shame. Several participants of the current study emphasised the felt importance of a therapist needing to have a pre-existing understanding of SP and its gravity in order to work effectively, feeling that a lack of knowledge would mean that they would be misunderstood. Past research has similarly identified concerns about professionals lacking in knowledge about SP (Gallinat et al., 2019b). This is likewise described in Bradley and Ecks' (2018) anthropological analysis of hair pulling where a participant considered health professionals to ""not understand" and therefore be "unable to help"" (p. 571). In the current study, participants' embracement of SP's diagnostic labelling seems to challenge research that proposes biomedical framing of distress to increase stigma (Angermeyer et al., 2011) and be experienced as invalidating (e.g. Geekie & Read, 2009), suggesting that the difference in stigma may depend on the nature of the experience being defined. The experience of participants in the current study suggests that the stigma of picking as an uncontrolled behaviour is felt to be worse than the stigma of a mental health condition which is considered beyond the individual's control. This corresponds with research that suggests that behaviours perceived to be 'controllable' are subject to higher public stigma (Botha & Dozois, 2015). These experiences and preferences around understanding and identifying SP demonstrate the power of the clinician and how a response lacking in understanding may be shaming (Lazare, 1987). Conversely, acceptance and normalisation of SP behaviours, and acknowledgement of related distress, may be powerful therapeutic tools.

The therapist's accepting presence may also support individuals to move away from intense patterns of self-objectification. Self-objectification seems central in many experiences of picking, evident in this study's description of intense analysis of skin, depersonalisation and the aesthetic self-criticism that may precipitate and/or follow picking (see the themes '*Zoning In to Zone Out'* and '*Shame of Picking'*). This objectification may detach individuals from their subjectivity (Broucek, 1991) leading to a sense of alienation from others, perhaps evident in the current study's overarching theme '*I Worry About People Looking and Judging Me*', and particularly in stories of reluctance to talk about picking with others. This underlines the critical importance of the therapist being careful not to objectify the client, such as by viewing the skin as an object to be fixed, and the imperative of seeing and welcoming the client's *whole* subjectivity, including the side of them that is drawn to picking.

Social support is considered to be a positive resource in appearance anxiety (Clarke et al., 2014) and has been shown to be protective in the severity of body dysmorphia symptoms (Marques et al., 2011). However, many participants in the current study expressed reluctance to talk to others and described feeling that the tenacity of their picking was dismissed by comments to 'just stop'.

Bradley and Ecks' (2018) study of family relationships alongside hair pulling similarly described parents commenting "why can't you just stop?" (p. 572), serving only to increase family tensions and increase hair pulling. It may be helpful to use therapy to build social support within understanding communities, such as group psychotherapy as recommended by Nakell (2015), within personal relationships, and in the online groups that many of the current study's participants praised. Online peer support has similarly been described as beneficial to those with other appearance altering skin conditions, such as by offering shared experience, connection and belonging (Iliffe & Thompson, 2019). However, steps to build social support should be taken carefully given the reality of bullying, dismissive and unhelpful comments from some others.

The Conflict of Picking and the Role of the Therapist

The conflict between the want to pick and the want to heal was apparent throughout the interviews and is strikingly evident in the juxtaposition of the drive to pick and later distress and regret. For many participants, picking seemed to be 'all or nothing' as they loved picking at the time and hated it in the aftermath. There was little evidence for self-empathy across states; participants generally struggled to be aware of the consequences of picking while picking, and equally they struggled to empathise with or forgive their picking after it had occurred. A few participants *had* adopted a more understanding stance towards their picking, though these tended to be participants who described the worst of their picking as being behind them. Division was also evident in participants' descriptions of being helpless to their picking, as if their minds were not their own when they picked. Conversely, participants described feelings of depersonalisation while picking, as if their *body* was not themselves.

These examples suggest a divide or loss of self-cohesion within individuals. When picking, the self who wants to heal is ignored, and when suffering the consequences of picking, the self who wants to pick is rejected as evidenced by the shame felt. There is a risk that therapy which seeks only to extinguish picking may collude with this lack of integration, considering the picking and its damage to be an unacceptable part of the self, adding to shame and exacerbating distress. Rather, the therapist has a responsibility to attend to and accept *all* elements of their client's experience. Other people's empathy and acceptance helps to regulate and re-integrate our selves (DeYoung, 2015), and 'self psychology' discusses creating the therapeutic conditions for individuals to develop a sense of themselves as an integrated whole (e.g. Kohut, 1984). This seems particularly pertinent where the skin is considered, as the skin allows for many of the formative sensory and bodily experiences that have been theorised to allow integration of the mind and body (Winnicot, 1945) and may be particularly significant in the development of a cohesive and contained self (Anzieu, 2016; Perlman, 2019).

Additionally, part of an individuals' distress at the damage of picking may come from the same place as the rejection of skin texture that precipitates picking. A therapeutic focus solely on improving the skin (through reducing picking damage) may unhelpfully collude with the self-objectification and intolerance of imperfection that appears to play a role in picking. Where perfectionism and disgust at the skin drive picking, it is not the therapist's job to work to help the client to be 'more perfect' or 'less disgusting'. This issue of self-objectification, where individuals' lack self-experience from within and the body is reduced to its appearance to others, seems relevant to those with disordered eating (Mancini et al., 2021), and has been suggested as a target for intervention (Rossi et al., 2021). Discussed in the context of disordered eating, the therapeutic journey towards balance between the view of the body as subject and object may be supported by a therapist's recognising and non-judgemental gaze (Esposito & Stanghellini, 2020) and therapeutic overemphasis on 'fixing' the body may risk collusion with the client (Dmochowski et al., 2015).

However, *picking behaviour is undeniably experienced as problematic by many,* and many would likely benefit from a reduction in the behaviour and an improvement in their skin's health. Concerns about collusion must be read while holding in mind the distress caused by picking both directly (e.g. pain, time lost) and indirectly (e.g. via shame), and with an appreciation for the reality of the stigmatisation that may drive shame. In balancing these issues, it seems imperative that therapy be driven by the individual's priorities, and that their decisions about the goals and directions of therapy need to be made in the light of an empathetic relationship that accept *all* parts of the client, including the part that picks, and the skin that is damaged.

Summary of Key Clinical Recommendations

1. Therapists might consider the cognitions that drive picking and the permissive cognitions which may undermine resistance, appreciating that these may be individual to the client. Consider factors and precipitants that influence these cognitions and cycles of behaviour, such as social experiences, circumstances, attention and avoidance of exposure.
2. Therapists might consider distress as a target of therapy to both reduce distress and weaken picking cycles. Where distress concerns appearance, consider appearance anxiety literature and ideas for intervention, such as use of CBT (e.g. Clarke et al., 2014) and ACT (e.g. Zucchelli et al., 2018) to work with shame focused on appearance. Where picking is used as coping, therapists might consider management of contextual emotion and traumatic stress as appropriate.
3. Therapists should explicitly communicate their acceptance of SP behaviours and normalise the experience, while empathetically attending to the individual's subjective and idiographic experience, sense-making and distress.
4. Therapists might consider supporting individuals to build social resources and support with a view to reducing shame, enlisting help in reducing picking and increasing social understanding. Careful attention should be paid to the realities of discrimination and unhelpful social experiences and how these might influence and/or steer where social support is sought and how conversations are managed.
5. Therapists should make efforts to welcome the individual's whole subjectivity by attending to and accepting all elements of their experience, avoiding collusion with client's self-objectification and fostering further division through rejecting picking (and the drive to pick) as unacceptable.

6. Therapists should be driven by individual priorities for therapy, determined in the context of an empathetic therapeutic relationship.

Summary of Recommendations for Research

1. Offering participants choice of interview modalities may improve both practical and emotional accessibility of the research and quality of data.
2. Use of IM as an interview modality may produce rich data, particularly where participants may want to manage their social and visual exposure. Boundaries of IM interviewing should be planned carefully, balancing needs and restrictions of both participant and researcher.
3. Further trans-diagnostic research may consider the relationship between SP & other presentations, such as hair pulling (in light of the similarities in cognitions identified by the current study and in Rehm et al's (2015) IPA study on hair pulling) and autistic stimming (in light of findings in the current study and similarities with accounts of stimming in Kapp et al's (2019) study of autistic adults).
4. Further research may further consider attention during SP and its role in coping, considering research from other domains considering attention, such as mind wandering and the attentional phenomenology of therapeutic activities.
5. Given the multiplicity of terms used for SP and its inclusion in various broader categories of behaviour, the study of SP may benefit from a systematic review.

Interview Modality Discussion and Reflections

The three themes presented at the end of the analysis under *'Participant Reflections on Interview Modality'* demonstrate that research may be most inclusive where it offers participants choice of interview modality, and avoids making assumptions as to which modalities are preferable or accessible. In the current study, the justifications for choice were underpinned by common issues such as participants' lifestyles, social styles, self-consciousness and style of reflecting. However, these common issues did not reliably predict participants' choice of interview modality; different participants felt that their needs would be met by different modalities. While there were clear preferences for IM among the current sample, IM as a singular interview modality would not have been accessible to all participants. Entrusting the decision about interview modality to the participants seems key to inclusivity as participants know best what they are comfortable with. This comfort may allow participants to engage with an interview and may be a step towards more flexible, non-hierarchical, participant-centred research design (e.g. Oakley, 1981).

This flexible approach challenges the more defined boundaries of traditional interview modalities, such as how long the interview is expected to take, as interviews are not entirely planned by the researcher. As a researcher I found that offering a range of interview choices was demanding of my time and energy, with each modality requiring a different timescale, boundaries and style of interview. However, I feel that is not possible to offer power and convenience to participants without being willing to relinquish some as researcher, and the extra effort was a worthwhile investment. Gibson's (2020) discussion of use of *WhatsApp* when interviewing young people about mental health similarly observes a transfer of power to participants that resulted in rich and meaningful interviews. A balance must be struck where the needs of both groups are reasonably met; where the researcher's commitment to interview is workable and effective, and where the participant is allowed enough flexibility to participate meaningfully.

The most popular interview modality was IM via the platforms of *Facebook Messenger* and *WhatsApp*. There are few examples of IM being used in research (e.g. Hinchcliffe & Gavin, 2009) and, where it has been used, it has tended to be used synchronously at a specified time. I chose to offer IM interviews at participants' convenience meaning that they were synchronous at times when the participant was available and responsive, and asynchronous when not. From my perspective as researcher, these interviews often (though not always) felt conversation and informal, a sentiment echoed within participants' feedback, and corresponding to the idea that "guiding tropes of [instant messenger] are "chat" and "conversation"" (Lewis & Fabos, 2005, p. 482). This suggests that IM may have both stylistic and felt differences to other written modalities such as email that may be significant in terms of developing rapport with participants. Many participants also appreciated the thinking space offered by IM modalities. Previous research has found that silences are considered less awkward in IM as compared with face-to-face exchanges (Lewis & Fabos, 2005), perhaps due to the expectation of, and thus permission for, a more disjointed conversation. In the current study, the time spent on each IM interview ranged widely from three days to four months, demonstrating the variety in synchronicity and pace set by the participant.

When using IM, I noticed that I needed to respond quickly to participants' messages in order to keep the interview moving. Most interviews took place in bursts of engagement, presumably when participants had free time, often in the evenings. On receiving participants' responses, I often seemed to have a limited window of time to respond in order to 'catch' them when available, and missing this window meant that I would need to wait for their later response. As well as meaning that the interview took much longer, this delay in response tended to give a more disjoined interview that felt unhelpful to our developing rapport. I felt a need to respond promptly to make the most of participants' time and to maintain momentum and interview cohesion.

Interviewing so responsively was difficult. I set relatively wide boundaries as to when I would respond (not after 9pm or before 9am) as I was keen to include the evening time when participants might be available to talk. This meant that I needed to be prepared to respond for twelve hours each day, which was a challenge to manage around family life and work commitments. I recall responding to participants throughout my toddler's bedtime and nappy changes, and having to stop every five minutes on a car journey to read and respond to messages. I recommend that researchers carefully consider how responsive they can be and set time boundaries accordingly. Where wide time boundaries are untenable, the researcher might consider limiting their response window to a shorter time that suits the participant, such as across a few hours in the evening. It may also be useful at the start of interview to talk to the participant about maintaining the momentum of the interview. However, in the current study, even the most asynchronous interviews were incredibly valuable.

Care would be needed to ensure that these voices were not excluded by the method becoming boundaried to the point of being restrictive or off-putting.

The most taxing aspect of IM was unexpected; that I felt that I needed to hold each participant, their story and their stage of interview constantly in mind so that I could be ready to respond to any messages promptly and without the time-burden of re-reading past messages. I found this very challenging, particularly towards the start of each interview where I had not yet established a mental image of the participant. I found it particularly difficult to have more than three or four interviews running concurrently; simultaneous interviews presented the additional challenge of making sure I did not mix up participants' stories. This difficulty has been similarly noted by researchers running concurrent email interviews (Fritz & Vandermause, 2018). The need to limit the number of interviews running, alongside the varied length of time taken to complete the interviews, meant that interviewing took far longer than I had expected. I would recommend that researchers are careful to manage expectations around likely interview start dates for those waiting.

Limitations of the Current Research

The intentions of the current study were to walk the fine line between presenting findings with theoretical transferability (Lincoln & Guba, 1985), in that they might have some meaning and application to therapists' work, while maintaining an idiographic, participant-focussed perspective. In this light, my analysis does not seek to make positivist statements about what SP is, but I hope that it summarises the insight of these current participants in a way that may be useful to therapists and clinicians. I will discuss factors that may impact transferability below.

A limitation of the current study was that, despite attempts to specifically recruit male participants, there are only two male perspectives represented. This is particularly noteworthy given indications that there may be a gender difference in SP's emotional experience (Prochwicz et al., 2016; Grant & Christenson, 2007), in the use and self-consciousness of displacement behaviours (Mohiyeddini et al., 2013a), and in more transdiagnostic concepts such as body shame, emotional expression and treatment seeking (Grabe et al., 2007; Polce-Lynch et al., 1998; Mackenzie et al., 2006). The lack of male participants may simply be representative of the bias towards females in SP prevalence, or could reflect gendered differences in perception of what picking is considered problematic or distressing. Alternatively, it may reflect the widely acknowledged difficulties in recruiting men to qualitative health research (e.g. Affleck et al., 2013; Oliffe & Thorne, 2007), or the use of interviews as a data collection method, which may be off-putting to men (Affleck et al., 2013).

A further limitation was that the study did not collect information about participants' race, meaning that it is not possible to identify which populations are represented in the data and which are not. It is possible that race may impact the experience of SP given the reported relationships between race/racial culture and domains relevant to SP, such as body image (e.g. Capodilupo & Kim, 2014) and emotional expression and regulation (e.g. Morelen et al., 2013). Despite these possible differences, large-scale SP prevalence studies have often reported on participants' racial demographics but not discussed them in relation to picking behaviours (e.g. Grant & Chamberlain, 2020; Hayes et al., 2009; Keuthen et al., 2010; Machado et al., 2018). Similarly, discussion of the characteristics of SP have tended to report demographics but not analysed them (e.g. Odlaug & Grant, 2008; Tucker et al., 2011), so any relationship between race and SP is unexplored.

It may also have been helpful to present other participant demographics and circumstances that may be related to picking. Previous research has found boredom to relate to picking (e.g. Roberts et al., 2015), picking to often occur when alone (Bohne et al., 2002), and social support to appear beneficial (Nakell, 2015). The current study further notes that free time, privacy and time alone appeared to precipitate picking for many, and that the presence of others sometimes reduced picking. As such, detail about participants' environmental factors, level of activity, living arrangements and/or social, family or romantic relationships may have been relevant to their experience and helped to give an impression of the circumstances of the current study's participants. These factors were instead explored qualitatively where participants raised them in response to questions about their picking.

Information regarding participants' dermatological conditions was not gathered at screening as it was intended to be discussed more qualitatively during interview, such as in response to questions about what on/in the skin is picked. This was intended to avoid issues in defining many dermatological conditions (such as how what is considered a 'condition' may be inconsistently defined), and to allow more space to individuals' subjective appraisal of how their picking relates to their skin (such as to include discussion of whether picking is deemed 'proportionate' to dermatological conditions or not; see discussion under 'Defining Problematic Skin Picking'). While many participants described dermatological conditions alongside or impacting their picking (such as keratosis pilaris and acne, see '*Introduction to the Participants and Interviews'*), the lack of demographic information concerning dermatological conditions limits how the current study's findings may be applied to dermatology-focussed medical and psychological services and their patients. Similarly, information regarding mental health comorbidities was not explicitly sought, in keeping with the study's trans-diagnostic intentions and focus on descriptions of lived experience over the (often problematic; see Pearce, 2014) delineations of diagnosis. Comorbidities were mentioned qualitatively by some participants, either in diagnostic terms or in more personal and/or descriptive language. Consequentially, the study's relevance to populations deemed to meet other mental health diagnoses is unclear, and any observations about participants' comorbid conditions are intended to illustrate the subjective experience, sense-making and/or context of participants' SP.

Participants were almost entirely sourced online and that the majority came from one of two online support forums, both hosted by the same social media platform (*Facebook*). Exclusive online recruitment may present issues of inclusion by only including those for whom technology is accessible (Lunnay et al., 2015), and the recruitment to sensitive research may be limited to those who have access to a suitably private space (Braun et al., 2020). The primary use of *Facebook* brings its own limitations, with an overrepresentation of young, white women (Whitaker et al., 2017). Additionally, the cultures of the support groups in which participants were recruited are likely to have some impact on discourse; individuals on these forums frequently share information about diagnosis and sense-making, which may shape the frameworks on which participants present their experience (e.g. Mason-Schrock, 1996). Furthermore, as shown in the current study, the comradery of these groups reduce shame. An individual might feel less inhibited about their own disclosure where they have previously seen the experience shared by others. This may mean that topics or perspectives not commonly circulated by the groups or outside of group culture may be less prevalent in interviews.

‘Service user involvement’ (SUI) may be considered beneficial to the design and implementation of psychology research (Faulkner, 2012). I considered the use of SUI at various stages of the research design, but did not utilise it for practical and philosophical reasons. Practical reasons and limitations included a lack of resources available for support or training and an inability to compensate SUI volunteers for their time. Philosophical reasons included concerns that use of SUI in some decisions might unintentionally lead to individuals being excluded, such as where service users’ decisions might be informed by a particular conceptualisation of SP. For example, I was aware, largely through my experience of reading posts to online forums, of a common and strong preference in many SP communities for use of diagnostic terminology (as was similarly discussed in the current study’s analysis). I felt that using SUI to determine the study’s language (such as in recruitment materials and interview) might therefore risk excluding those without a formal diagnosis and would be counter to the study’s trans-diagnostic ethos. Instead, I chose to use the deliberately inclusive, accessible and more theoretically neutral terms such as ‘skin picking’. SUI was also considered as an option when designing interview modalities, but rather than use SUI, I decided to offer each individual participant maximum choice and flexibility, essentially involving each individual participant in the design of their interview. There were elements of the design that I feel may have benefitted from SUI, such as when planning areas of interest and focus for the interview. The practical limitations mentioned above meant that, instead of using SUI, I drew on my previous learning from conducting more naturalistic research on SP (see Anderson & Clarke, 2019) and strove to adapt the interviews according to participant feedback. Nonetheless, a lack of SUI may have meant differences in my areas of focus as compared to the priorities of service users.

The current study was developed in line with Braun and Clarke's (2006, 2021) reflexive approach to TA, whereby researcher subjectivity is considered to be both inevitable and key. Themes are not considered to be objects, but rather are deemed to "reside in the researcher's thoughts" (Ho et al., 2017, p. 1760). Themes were developed through researcher immersion with the data, reflection and rigorous "systemic analytic engagement with the data set" (Braun & Clarke, 2021, p. 7), in keeping with Braun and Clarke's (2006) suggestions for research quality and rigour. This valuing of subjective interpretation, as described in the *Method*, meant that more positivist assessments of reliability and replicability (e.g. Boyatzis, 1998) were deemed "incommensurate with the relational analyses… [that] participatory researchers strive to conurture" (Guishard, 2018, p. 402) and incoherent with the theoretical grounding of the study. As such, measures seeking to promote the reliability and accuracy of the analysis were not employed. For example, processes such as 'member checking' or 'participant validation' (e.g. Morrow, 2005), where participants check researchers' interpretation of their data, were not used, as the analysis sought to go beyond participants' explicit statements and included discussion of more supressed meanings, subtleties and contradictions, meaning that participant feedback may have been difficult to use constructively (Yardley, 2008). Measures such as comparing different researcher codes to assess 'inter-coder reliability' (Boyatzis, 1998) were deemed inconsistent with the study's interpretative approach; the intention was not to produce codes independent of the researcher (Yardley, 2008). However, my supervisor independently coded three interviews for purposes of my reflexivity. Similarly, the current study did not use multiple qualitative analysts to review coding (Elliott et al., 1999), though I did individually check over my interpretation of the data for "discrepancies, overstatements, or errors" (Elliott et al., 1999, p.222), and consider participant data that disconfirmed or deviated from the themes and patterns described (Lincoln & Guba, 1985; Yardley, 2008); these divergent cases were reported on where possible to contextualise the analysis. I did not use 'triangulation' with external factors or quantitative data (Elliott et al., 1999), though the research has been discussed in the context of findings largely from quantitative perspectives. The current study does not seek to and therefore cannot be assumed to state an objective ‘truth’ about the experience of SP nor be representative of all who pick their skin; this would reflect neither the intentions of the research nor the methodology employed.

Both the literature review and analysis of this study have highlighted phenomenological overlaps between SP and studies in different fields, such as the calming effect of repetitive behaviours in animals (Troisi, 2002), general human behaviour (Troisi, 2002; Mohiyeddini & Semple, 2013), autistic communities (Kapp et. al., 2019) and those who pull their hair (Rehm et al., 2015). The current study took a non-diagnostic perspective on SP, using expansive definitions of picking behaviour and distress and without excluding individuals for having other diagnoses. However, it did delineate in terms of behaviour requiring that participants engage in the specific act of ‘picking’. Given the transdiagnostic approach, it may have been useful to loosen the definition of behaviour to allow for the inclusion of other similar acts, such as self-directed biting or scratching. As it was, a couple of participants did talk about other similar behaviours, and these were included within the analysis where they related closely to picking (e.g. both biting and picking the skin on fingers). However, it may have been beneficial to the study’s transdiagnostic approach to use a broader definition of behaviour.

Conclusion

The current study presents a picture of the problem of picking from the perspective of those with lived experience. It gives insight into some of the mechanisms of the appeal and tenacity of picking behaviour, the circumstances and cognitions that deplete resistance to picking, and the distress that follows. It presents the problem of picking not simply as a problem of picking drive and *behaviour*, but as a problem of *emotional context* and *emotional consequence*.

The current study adds weight to the assertion by previous researchers that SP has a complex and heterogenous presentation, both between and within individuals. Themes that were powerful and pivotal for some, such as that picking were a form of emotional relief and coping, were less important if not irrelevant for others. The heterogeneity and complexity of SP means that individual cases may be best understood by considering and responding what is meaningful to the individual. The more transdiagnostic fields of appearance anxiety, shame and body shame, trauma, impulsivity and emotion regulation may more flexibly and precisely inform this work.

This thesis reveals the power that professionals have in shaping the experience of those seeking help with SP. Their response may shame or accept. They may steer therapy either towards a focus on picking or a focus on distress, and the discussion in this thesis has highlighted concerns about a focus on one occluding the other. Those seeking help may expect professionals to have an understanding of SP, and a pre-existing framework of typical patterns and experiences may certainly be useful for therapists who have no experience of SP. However, any a priori insight into the SP experience should not obscure the therapists’ focus on the individual presenting in front of them. An empathetic, non-judgemental therapeutic perspective that accepts all elements of the individual, including those which the individual rejects, may provide the space needed to develop insight into their SP. From this position, individuals may be able to make undefended, self-determined choices about where and how they choose to change.

References

Abramovitch, A., Berman, N., Calkins, A., & Wilhelm, S. (2015). Obsessive-Compulsive and related disorders. In P. H. Blaney, R. F. Krueger & T. Millon (Eds.), *Oxford textbook of psychopathology* (3rd ed., pp. 163-190). Oxford University Press.

Abramowitz, J. S., & Jacoby, R. J. (2015). Obsessive-compulsive and related disorders: A critical review of the new diagnostic class. *Annual Review of Clinical Psychology, 11*, 165-186. https://doi.org/10.1146/annurev-clinpsy-032813-153713

Abramson, L. Y., Metalsky, G. I., & Alloy, L. B. (1989). Hopelessness depression: A theory-based

subtype of depression. *Psychological Review, 96*(2), 358-372. https://doi.org/10.1037/0033-295X.96.2.358

Affleck, W., Glass, K. C., & Macdonald, M. E. (2013). The limitations of language: Male participants, stoicism, and the qualitative research interview. *American Journal of Men's Health, 7*(2), 155-162. https://doi.org/10.1177/1557988312464038

Allen, J. L., Mason, T. B., Stout, D. M., & Rokke, P. D. (2018). Emotion specific effects on attentional bias among women with shape and weight concerns. *Cognitive Therapy and Research, 42*(5), 612-621. https://doi.org/10.1007/s10608-018-9916-7

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental Disorders* (5th ed.). American Psychiatric Association.

Anderson, S., & Clarke, V. (2019). Disgust, shame and the psychosocial impact of skin picking: Evidence from an online support forum*. Journal of Health Psychology, 24*(13), 1773-1784. https://doi.org/10.1177%2F1359105317700254

Angermeyer, M. C., Holzinger, A., Carta, M. G., & Schomerus, G. (2011). Biogenetic explanations and public acceptance of mental illness: Systematic review of population studies. *The British Journal of Psychiatry, 199*(5), 367-372. https://doi.org/10.1192/bjp.bp.110.085563

Anzieu, D. (2016). *The skin-ego* (N. Segal, Trans.). Karnac Books, Ltd. (Original work published 1995)

Arnold, L. M., Auchenbach, M. B., & McElroy, S. L. (2001). Psychogenic excoriation: Clinical features, proposed diagnostic criteria, epidemiology and approaches to treatment. *Central Nervous System Drugs, 15*(5), 351-359. https://doi.org/10.2165/00023210-200115050-00002

Arnold, L. M., McElroy, S. L., Mutasim, D. F., Dwight, M. M., Lamerson, C. L., & Morris, E. M. (1998). Characteristics of 34 adults with psychogenic excoriation. *Journal of Clinical Psychiatry, 59*(10), 509-514. https://doi.org/10.4088/jcp.v59n1003

Arnold, L. M., Mutasim, D. F., Dwight, M. M., Lamerson, C. L., Morris, E. M., & McElroy, S. L. (1999). An open clinical trial of fluvoxamine treatment of psychogenic excoriation. *Journal of Clinical Psychopharmacology, 19*(1), 15-18. https://doi.org/10.1097/00004714-199902000-00005

Aureli, F. (1997). Post-conflict anxiety in nonhuman primates: The mediating role of emotion in conflict resolution. *Aggressive Behavior, 23*(5), 315—328. https://doi.org/10.1002/(SICI)1098-2337(1997)23:5%3C315::AID-AB2%3E3.0.CO;2-H

Aureli, F., Preston, S. D., & de Waal, F. B. M. (1999). Heart rate responses to social interactions in free-moving rhesus macaques (Macaca mulatta): A pilot study. *Journal of Comparative Psychology, 113*(1), 59-65. https://doi.org/10.1037/0735-7036.113.1.59

Azrin, N. H., & Nunn, R. G. (1973). Habit-reversal: A method of eliminating nervous habits and tics. *Behaviour Research and Therapy, 11*(4), 619-628. https://doi.org/10.1016/0005-7967(73)90119-8

Baca-Garcia, E., Perez-Rodriguez, M. M., Basurte-Villamor, I., Del Moral, A. L. F., Jimenez-Arriero, M. A., De Rivera, J. L. G., Saiz-Rui, J., & Oquendo, M. A. (2007). Diagnostic stability of psychiatric disorders in clinical practice. *The British Journal of Psychiatry, 190*(3), 210-216. https://doi.org/10.1192/bjp.bp.106.024026

Barnier, E. M., & Collison, J. (2019). Experimental induction of self-focused attention via mirror gazing: Effects on body image, appraisals, body-focused shame, and self-esteem. *Body Image, 30*, 150-158. https://doi.org/10.1016/j.bodyim.2019.07.003

Bartky, S. L. (1990). *Femininity and domination: Studies in the phenomenology of oppression.* Routledge

Berberick, S. N. (2010). The objectification of women in mass media: Female self-image in misogynist culture. *The New York Sociologist, 5*(2). 1-15. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.694.8981&rep=rep1&type=pdf

Berinsky, A. J., Huber, G. A., & Lenz, G. S. (2012). Evaluating online labor markets for experimental research: Amazon. com's Mechanical Turk. *Political Analysis, 20*(3), 351-368. https://doi.org/10.1093/pan/mpr057

Bick, E. (1968). The experience of the skin in early object relations. *International Journal of Psychoanalysis, 49*, 484–486. https://search.proquest.com/openview/32385dc1a6aa2df24ea9c0fca233fade/1?pq-origsite=gscholar&cbl=1818729

Boccia, M. L., Reite, M., & Laudenslager, M. (1989). On the physiology of grooming in a pigtail macaque. *Physiology & Behavior, 45*(3), 667-670. https://doi.org/10.1016/0031-9384(89)90089-9

Bohne, A., Keuthen, N. J., & Wilhelm, S. (2005). Pathologic hairpulling, skin picking, and nail biting. *Annals of Clinical Psychiatry, 17*(4), 227-232.

Bohne, A., Wilhelm, S., Keuthen, N. J., Baer, L., & Jenike, M. A. (2002). Skin picking in German students: Prevalence, phenomenology, and associated characteristics. *Behavior Modification, 26*(3), 320-339. https://doi.org/10.1177%2F0145445502026003002

Botha, F. B., & Dozois, D. J. A. (2015). The influence of emphasizing psychological causes of depression on public stigma. *Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement, 47*(4), 313 -320. https://doi.org/10.1037/a0039611

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. SAGE Publications.

Bradley, B., & Ecks, S. (2018). Disentangling Family Life and Hair Pulling: Trichotillomania and Relatedness. *Medical Anthropology, 37*(7), 568-581. https://doi.org/10.1080/01459740.2018.1476509

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners.* Sage.

Braun, V., & Clarke, V. (2021). Conceptual and design thinking for thematic analysis. *Qualitative Psychology.* Advance online publication. https://doi.org/10.1037/qup0000196

Braun, V., Clarke, V., Boulton, E., Davey, L., & McEvoy, C. (2020). The online survey as a *qualitative* research tool. *International Journal of Social Research Methodology*. Online publication. https://doi.org/10.1080/13645579.2020.1805550

British Psychological Society (2013). *Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift* (DCP Position Statement). British Psychological Society. Retrieved from https://www.bps.org.uk/sites/bps.org.uk/files/Member%20Networks/Divisions/DCP/Classification%20of%20behaviour%20and%20experience%20in%20relation%20to%20functional%20psychiatric%20diagnoses.pdf

British Psychological Society (2018). *Code of ethics and conduct: Guidance published by the ethics committee of the British Psychological Society*. British Psychological Society. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf

British Psychological Society (2014). *Code of human research ethics*. British Psychological Society. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf

Broucek, F. J. (1991), *Shame and the self.* Guildford Press

Bull, R., Rumsey, N. (1988). *The social psychology of facial appearance.* Springer-Verlag.

Calogero, R. M., Davis, W. N., & Thompson, J. K. (2005). The role of self-objectification in the experience of women with eating disorders. *Sex Roles, 52* ,43–50. https://doi.org/10.1007/s11199-005-1192-9

Capodilupo, C. M., & Kim, S. (2014). Gender and race matter: The importance of considering intersections in Black women's body image. *Journal of Counseling Psychology, 61*(1), 37-49. https://doi.org/10.1037/a0034597

Capriotti, M. R., Ely, L. J., Snorrason, I., & Woods, D. W. (2015). Acceptance-enhanced behavior therapy for excoriation (skin-picking) disorder in adults: A clinical case series. *Cognitive and Behavioral Practice, 22*(2), 230-239. https://doi.org/10.1016/j.cbpra.2014.01.008

Castellanos, F. X., Ritchie, G. F., Marsh, W. L., & Rapoport, J. L. (1996). DSM-IV stereotypic movement disorder: Persistence of stereotypies of infancy in intellectually normal adolescents and adults. *The Journal of Clinical Psychiatry, 57*(3), 116-122.

Castles, D. L., Whiten, A., & Aureli, F. (1999). Social anxiety, relationships and self-directed behaviour among wild female olive baboons. *Animal Behaviour, 58*(6), 1207-1215. https://doi.org/10.1006/anbe.1999.1250

Charmaz, K., & Rosenfeld, D. (2006). Reflections of the Body, Images of Self: Visibility and Invisibility in Chronic Illness and Disability. In D. Waskul & P. Vannini (Eds.), *Body/embodiment: Symbolic interaction and the sociology of the body* (pp. 35-49). Ashgate Publishing.

Choe, E. K., Consolvo, S., Jung, J., Harrison, B., & Kientz, J. A. (2011, September). Living in a glass house: A survey of private moments in the home. *UbiComp '11: Proceedings of the 13th International Conference on Ubiquitous Computing*, 41-44. https://doi.org/10.1145/2030112.2030118

Christenson, G. A., Mackenzie, T. B., & Mitchell, J. E. (1991). Characteristics of 60 adult hair pullers. *The American Journal of Psychiatry, 148*(3), 365–370. https://doi.org/10.1176/ajp.148.3.365

Claes, L., & Vandereycken, W. (2007). Self-injurious behavior: Differential diagnosis and functional differentiation. *Comprehensive Psychiatry, 48*(2), 137-144. https://doi.org/10.1016/j.comppsych.2006.10.009

Clarke, A., Thompson, A. R., Jenkinson, E., Rumsey, N., & Newell, R. (2014). *CBT for appearance anxiety: Psychosocial interventions for anxiety due to visible difference*. John Wiley & Sons.

Clarke, E. N., Thompson, A. R. and Norman, P. 2020. Depression in people with skin conditions: Theeffects of disgust and self-compassion. *British Journal of Health Psychology 25*(3), 540-557. https://doi.org/10.1111/bjhp.12421

Clerkin, E. M., & Teachman, B. A. (2008). Perceptual and cognitive biases in individuals with body dysmorphic disorder symptoms. *Cognition and Emotion, 22*(7), 1327-1339. https://doi.org/10.1080/02699930701766099

Cook, C. (2012). Email interviewing: Generating data with a vulnerable population. *Journal of Advanced Nursing, 68*(6), 1330–1339. https://doi.org/10.1111/j.1365-2648.2011.05843.x

Corey, K. C., Cheng, C. E., Irwin, B., & Kimball, A. B. (2013). Self-reported help-seeking behaviors and treatment choices of adolescents regarding acne. *Pediatric Dermatology, 30*(1), 3h-41. https://doi.org/10.1111/j.1525-1470.2012.01807.x

Cosgrove, L., & Krimsky, S. (2012). A comparison of DSM-IV and DSM-5 panel members' financial associations with industry: a pernicious problem persists. *PLoS Medicine, 9*(3), e1001190. https://doi.org/10.1371/journal.pmed.1001190

Craddock, N., & Owen, M. J. (2007). Rethinking psychosis: The disadvantages of a dichotomous classification now outweigh the advantages. *World Psychiatry, 6*(2), 84-91. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2219899/

Crosswell, A. D., Coccia, M., & Epel, E. S. (2020). Mind wandering and stress: When you don't like the present moment. *Emotion, 20*(3), 403–412. https://doi.org/10.1037/emo0000548

Dalgard, F. J., Gieler, U., Tomas-Aragones, L. , Lien, L. , Poot, F., Jemec, G. B. E., Misery, L., Szabo, C., Linder, D., Sampogna, F., Evers, A. W. M., Halvorsen, J. A., Balieva, F., Szepietowski, J., Romanov,D., Marron, S. E., Altunay, I. K., Finlay, A. Y., Salek, S. S., & Kupfer, J. (2015). The psychological burden of skin diseases: a cross-sectional multicenter study among dermatological out-patients in 13 European countries. *Journal of Investigative Dermatology, 135*(4), 984-991. https://doi.org/10.1038/jid.2014.530

Dawydiak, E. J., Stafford, H. E., Stevenson, J. L., & Jones, B. C. (2020). Pathogen disgust predicts stigmatization of individuals with mental health conditions. *Evolutionary Psychological Science, 6*, 60-63. https://doi.org/10.1007/s40806-019-00208-x

Deckersbach, T., Wilhelm, S., & Keuthen, N. (2003). Self-injurious skin picking: Clinical characteristics, assessment methods and treatment modalities. *Brief Treatment and Crisis Intervention, 3*(2), 249-260. https://triggered.edina.clockss.org/ServeContent?url=http://btci.stanford.clockss.org%2Fcgi%2Freprint%2F3%2F2%2F249.pdf

Deckersbach, T., Wilhelm, S., Keuthen, N. J., Baer, L., & Jenike, M. A. (2002). Cognitive-behavior therapy for self-injurious skin picking: A case series. *Behavior Modification, 26*(3), 361-377. https://doi.org/10.1177/0145445502026003004

Denys, D., van Megen, H. J. G. M., & Westenberg, H. G. M. (2003). Emerging skin-picking behaviour after serotonin reuptake inhibitor-treatment in patients with obsessive–compulsive disorder: Possible mechanisms and implications for clinical care. *Journal of Psychopharmacology, 17*(1), 127-129. https://doi.org/10.1177/0269881103017001718

DeSantis, L., & Ugarriza, D. N. (2000). The concept of theme as used in qualitative nursing research. Western Journal of Nursing Research, 22(3), 351-372. https://doi.org/10.1177/019394590002200308

DeYoung, P.A. (2015). *Understanding and treating chronic shame: A relational/neurobiological approach*. Routledge.

Dixon, L. J., & Snorrason, Í. (2019). Prevalence and clinical characteristics of skin picking among adults with skin disease symptoms. *Journal of Obsessive-Compulsive and Related Disorders, 22,* 100454. https://doi.org/10.1016/j.jocrd.2019.100454

Dolezal, L. (2015). *The body and shame: Phenomenology, feminism, and the socially shaped body.* Lexington Books.

Dmochowski, S., Ben-Shahar, A. R., & Carleton, J. (2015). Body psychotherapeutic treatments for eating disorders. In G. Marlock, Weiss, H., Young, C., & Soth, M. (Eds.), The Handbook of Body Psychotherapy and Somatic Psychology (pp.724-736), North Atlantic Books.

Dr. Sandra Lee (aka Dr. Pimple Popper). *About* [YouTube Page]. YouTube. Retrieved December 31, 2020, from https://www.youtube.com/user/DrSandraLee/about

Duboscq, J., Agil, M., Engelhardt, A., & Thierry, B., (2014). The function of post-conflict interactions: New prospects from the study of a tolerant species of primate. *Animal Behaviour, 87*, 107–120. https://doi.org/10.1016/j.anbehav.2013.10.018

Dunbar, R. I. M. (2010). The social role of touch in humans and primates: behavioural function and neurobiological mechanisms. *Neuroscience & Biobehavioral Reviews, 34*(2), 260-268. https://doi.org/10.1016/j.neubiorev.2008.07.001

Dures, E., Morris, M., Gleeson, K., & Rumsey, N. (2011). The psychosocial impact of epidermolysis bullosa. *Qualitative Health Research, 21*(6), 771-782. https://doi.org/10.1177/1049732311400431

Egan, J., Chenoweth, L. & McAuliffe, D. (2006). Email-facilitated qualitative interviews with traumatic brain injury survivors: A new and accessible method. *Brain Injury, 20*(12), 1283-1294. https://doi.org/10.1080/02699050601049692

Egan, K., Harcourt, D., & Rumsey, N. (2011). A qualitative study of the experiences of people who identify themselves as having adjusted positively to a visible difference. *Journal of Health Psychology, 16*(5), 739-749. https://doi.org/10.1177%2F1359105310390246

Elliott, A. J., & Fuqua, R. W. (2000). Trichotillomania: Conceptualization, measurement, and treatment. *Behavior Therapy, 31*(3), 529-545. https://doi.org/10.1016/S0005-7894(00)80029-5

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*(3), 215-229. https://doi.org/10.1348/014466599162782

Esposito, C. M., & Stanghellini, G. (2020). The pathogenic and therapeutic potential of the gaze of the other in the clinic of “eating disorders.” *Psychopathology, 3*, 1–7. https://doi.org/10.1159/000509625

Faulkner, A. (2011). Participation and service user involvement. In D. Harper & A. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 39-54). Wiley-Blackwell.

Favaro, A., Ferrara, S., & Santonastaso, P. (2007). Self-injurious behavior in a community sample of young women: Relationship with childhood abuse and other types of self-damaging behaviors. *The Journal of Clinical Psychiatry, 68*(1), 122-131. https://doi.org/10.4088/JCP.v68n0117

Ferrão, Y. A., Almeida, V. P., Bedin, N. R., Rosa, R., & Busnello, E. D. (2006). Impulsivity and compulsivity in patients with trichotillomania or skin picking compared with patients with obsessive-compulsive disorder. *Comprehensive Psychiatry, 47*(4), 282-288. https://doi.org/10.1016/j.comppsych.2005.11.005

Ferreira, C., Pinto-Gouveia, J., & Duarte, C. (2013). Self-compassion in the face of shame and body image dissatisfaction: Implications for eating disorders. *Eating Behaviors, 14*(2), 207-210. https://doi.org/10.1016/j.eatbeh.2013.01.005

Flessner, C. A., Busch, A. M., Heideman, P. W., & Woods, D. W. (2008a). Acceptance-enhanced behavior therapy (AEBT) for trichotillomania and chronic skin picking: Exploring the effects of component sequencing. *Behavior Modification, 32*(5), 579-594. https://doi.org/10.1177%2F0145445507313800

Flessner, C. A., & Woods, D. W. (2006). Phenomenological characteristics, social problems, and the economic impact associated with chronic skin picking. *Behavior Modification, 30*(6), 944-963. https://doi.org/10.1177%2F0145445506294083

Flessner, C. A., Conelea, C. A., Woods, D. W., Franklin, M. E., Keuthen, N. J., & Cashin, S. E. (2008b). Styles of pulling in trichotillomania: Exploring differences in symptom severity, phenomenology, and functional impact. *Behaviour Research and Therapy, 46*(3), 345-357. https://doi.org/10.1016/j.brat.2007.12.009

Flessner, C. A., Mouton-Odum, S., Stocker, A. J., & Keuthen, N. J. (2007). StopPicking.com: Internet-based treatment for self-injurious skin picking. *Dermatology Online Journal, 13*(4), 3. Retrieved from https://escholarship.org/uc/item/1dx97474

Frances, A. J., & Nardo, J. M. (2013). ICD-11 should not repeat the mistakes made by DSM-5. *The British Journal of Psychiatry, 203*(1), 1-2. https://doi.org/10.1192/bjp.bp.113.127647

Fritz, R. L., & Vandermause, R. (2018). Data collection via in-depth email interviewing: Lessons from the field. *Qualitative Health Research, 28*(10), 1640-1649. https://doi.org/10.1177%2F1049732316689067

Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: Literature review. *Journal of Advanced Nursing, 49*(6), 616-623. https://doi.org/10.1111/j.1365-2648.2004.03331.x

Galinsky, T. L., Rosa, R. R., Warm, J. S., & Dember, W. N. (1993). Psychophysical determinants of stress in sustained attention. *Human Factors, 35*(4), 603-614. https://doi.org/10.1177/001872089303500402

Gallinat, C., Moessner, M., Claes, L., & Müller, A. (2019a). Skin picking in patients with obesity: Associations with impulsiveness and self-harm*. Scandinavian Journal of Psychology, 60*(4), 361-368. https://doi.org/10.1111/sjop.12536

Gallinat, C., Moessner, M., Haenssle, H. A., Winkler, J. K., Backenstrass, M., & Bauer, S. (2019b). Help-seeking attitudes and experiences in individuals affected by skin picking. *Journal of Obsessive-Compulsive and Related Disorders, 23*, 100483. https://doi.org/10.1016/j.jocrd.2019.100483

Gallinat, C., Moessner, M., Haenssle, H. A., Winkler, J. K., Backenstrass, M., & Bauer, S. (2019c). SaveMySkin: An Internet-based self-help intervention for skin picking. Study protocol for a randomized pilot study. *Contemporary Clinical Trials Communications, 13*, 100315. https://doi.org/10.1016/j.conctc.2018.100315

Geekie, J., & Read, J. (2009). *Making sense of madness: Contesting the meaning of schizophrenia.* Routledge.

Gelinas, B. L., & Gagnon, M. M. (2013). Pharmacological and psychological treatments of pathological skin-picking: a preliminary meta-analysis. *Journal of Obsessive-Compulsive and Related Disorders, 2*(2), 167-175. https://doi.org/10.1016/j.jocrd.2013.02.003

Genuth, A., & Drake, J. E. (2019). The benefits of drawing to regulate sadness and anger: Distraction versus expression. *Psychology of Aesthetics, Creativity, and the Arts.* Advance online publication. https://doi.org/10.1037/aca0000265

Gibson, K. (2020). Bridging the digital divide: Reflections on using WhatsApp instant messenger interviews in youth research. *Qualitative Research in Psychology*. Online publication. https://doi.org/10.1080/14780887.2020.1751902

Gibson, L. (2017). Generating interview data via email. In V. Braun, V. Clarke, & D. Gray (Eds.), *Collecting qualitative data: A practical guide to textual, media and virtual techniques* (pp. 213-234). Cambridge University Press.

Gilbert, P., & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 263–325). Routledge.

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy, 13*(6), 353-379. https://doi.org/10.1002/cpp.507

Gough, B., & Madill, A. (2012). Subjectivity in psychological research: From problem to prospect. *Psychological Methods, 17*(3), 374-384. https://doi.org/10.1037/a0029313

Grabe, S., Hyde, J. S., & Lindberg, S. M. (2007). Body objectification and depression in adolescents: The role of gender, shame, and rumination. *Psychology of Women Quarterly, 31*(2), 164-175. https://doi.org/10.1111/j.1471-6402.2007.00350.x

Grant, J. E., & Chamberlain, S. R. (2020). Prevalence of skin picking (excoriation) disorder. *Journal of Psychiatric Research, 130,* 57-60. https://doi.org/10.1016/j.jpsychires.2020.06.033

Grant, J. E., & Christenson, G. A. (2007). Examination of gender in pathologic grooming behaviors. Psychiatric Quarterly, 78(4), 259-267. https://doi.org/10.1007/s11126-007-9045-z

Grant, J. E., Leppink, E., & Chamberlain, S. (2015a). Body focused repetitive behavior disorders and perceived stress: Clinical and cognitive associations. *Journal of Obsessive-Compulsive and Related Disorders, 5*, 82-86. https://doi.org/10.1016/j.jocrd.2015.02.001

Grant, J. E., Mernard, W. & Phillips, K. A. (2006). Pathological skin picking in individuals with body dysmorphic disorder. *General Hospital Psychiatry, 28*(6), 487-493. https://doi.org/10.1016/j.genhosppsych.2006.08.009

Grant, J. E., Potenza, M.N. (2006). Compulsive aspects of impulse-control disorders. *Psychiatric Clinics, 29*(2), 539-551. https://doi.org/10.1016/j.psc.2006.02.002

Grant, J. E., Redden, S. A., Leppink, E. W., & Odlaug, B. L. (2015b). Skin picking disorder with co-occurring body dysmorphic disorder. *Body Image, 15,* 44-48. https://doi.org/10.1016/j.bodyim.2015.05.003

Grant, J. E., Redden, S. A., Leppink, E. W., Odlaug, B. L., & Chamberlain, S. R. (2016). Psychosocial dysfunction associated with skin picking disorder and trichotillomania. *Psychiatry Research, 239*, 68-71. https://doi.org/10.1016/j.psychres.2016.03.004

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioral Assessment*, *26*(1), 41-54. https://doi.org/10.1023/B:JOBA.0000007455.08539.94

Greenwald, A. G., & Banaji, M. R. (1995). Implicit social cognition: attitudes, self-esteem, and stereotypes. *Psychological Review, 102*(1), 4-27. https://psycnet.apa.org/buy/1995-17407-001

Griesemer, R. D. (1978). Emotionally triggered disease in a dermatologic practice. *Psychiatric Annals, 8*(8), 49-56. https://doi.org/10.3928/0048-5713-19780801-08

Grosz, E. (1994). *Volatile bodies: Toward a corporeal feminism*. Indiana University Press.

Guishard, M. A. (2018). Now’s not the time! Qualitative data repositories on tricky ground: Comment on Dubois et al. (2018). *Qualitative Psychology, 5*(3), 402-408. https://doi.org/10.1037/qup0000085

Gupta, M. A., Gupta, A. K., & Schork, N. J. (1996). Psychological factors affecting self-excoriative behavior in women with mild-to-moderate facial acne vulgaris. *Psychosomatics, 37*(2), 127-130. https://doi.org/10.1016/S0033-3182(96)71578-5

Gupta, M. A., Vujcic, B., & Gupta, A. K. (2017). Dissociation and conversion symptoms in dermatology. *Clinics in Dermatology, 35*(3), 267-272. https://doi.org/10.1016/j.clindermatol.2017.01.003

Gustison, M., MacLarnon, A., Wiper, S. & Semple, S. (2012). An experimental study of behavioural coping strategies in free-ranging female Barbary macaques (Macaca sylvanus). *Stress, 15*(6), 608—617. https://doi.org/10.3109/10253890.2012.668589

Hajcak, G., Franklin, M. E., Simons, R. F., & Keuthen, N. J. (2006). Hairpulling and skin picking in relation to affective distress and obsessive-compulsive symptoms. *Journal of Psychopathology and Behavioral Assessment, 28*(3), 177-185. https://doi.org/10.1007/s10862-005-9001-x

Halvorsen, J. A., Stern, R. S., Dalgard, F., Thoresen, M., Bjertness, E., & Lien, L. (2011). Suicidal ideation, mental health problems, and social impairment are increased in adolescents with acne: A population-based study. *Journal of Investigative Dermatology, 131*(2), 363-370. https://doi.org/10.1038/jid.2010.264

Hamilton, R. J. & Bowers, B. J. (2006). Internet recruitment and e-mail interviews in qualitative studies. *Qualitative Health Research, 16*(6), 821-835. https://doi.org/10.1177%2F1049732306287599

Hanna, P. (2012). Using internet technologies (such as Skype) as a research medium: A research note. *Qualitative Research, 12*(2), 239-242. https://doi.org/10.1177%2F1468794111426607

Hanna, P. & Mwale, S. (2017). Virtual face-to-face interviewing. In V. Braun, V. Clarke, & D. Gray (Eds.), *Collecting qualitative data: A practical guide to textual, media and virtual techniques* (pp. 256-274). Cambridge University Press.

Hansen, D. J., Tishelmian, A. C., Hawkins, R. P., & Doepke, K. J. (1990). Habits with potential as disorders: Prevalence, severitv, and other characteristics among college students. *Behavior Modification, 14*(1), 66-80. https://doi.org/10.1177%2F01454455900141005

Hari, J. (2015). *Chasing the scream: The first and last days of the war on drugs*. Bloomsbury.

Harlow, H. F., & Harlow, M. K. (1962). Social deprivation in monkeys. *Scientific American, 207*(5), 136-150. https://doi.org/10.1038/scientificamerican1162-136

Hayes, S. L., Storch, E. A., & Berlanga, L. (2009). Skin picking behaviours: An examination of the prevalence and severity in a community sample. *Journal of Anxiety Disorders, 23*(3), 314-319. https://doi.org/10.1016/j.janxdis.2009.01.008

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2011). *Acceptance and commitment therapy: The process and practice of mindful change*. Guilford Press.

Hays, D. G., & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings*. Guilford Press.

Heath, J., Williamson, H., Williams, L., & Harcourt, D. (2018). "It's just more personal": Using multiple methods of qualitative data collection to facilitate participation in research focusing on sensitive subjects. *Applied Nursing Research, 43*, 30-35. https://doi.org/10.1016/j.apnr.2018.06.015

Heatherton, T. F., & Baumeister, R. F. (1991). Binge eating as escape from self-awareness. *Psychological Bulletin, 110*(1), 86-108. https://doi.org/10.1037/0033-2909.110.1.86

Heimpel, S. A., Wood, J. V., Marshall, M. A., & Brown, J. D. (2002). Do people with low self-esteem really want to feel better? Self-esteem differences in motivation to repair negative moods. *Journal of Personality and Social Psychology, 82*(1), 128-147. https://doi.org/10.1037/0022-3514.82.1.128

Hennings, C., & Miller, J. (2013). Illicit drugs: What dermatologists need to know. *Journal of the American Academy of Dermatology, 69*(1), 135-142. https://doi.org/10.1016/j.jaad.2012.12.968

Hinchcliffe, V., & Gavin, H., (2009). Social and virtual networks: Evaluating synchronous online interviewing using instant messenger. *The Qualitative Report, 14*(2), 318–40.

Ho, K. H., Chiang, V. C., & Leung, D. (2017). Hermeneutic phenomenological analysis: the 'possibility' beyond 'actuality' in thematic analysis. *Journal of Advanced Nursing*, *73*(7), 1757-1766.

Hollander, E., & Benzaquen, S. D. (1997). The obsessive-compulsive spectrum disorders. *International Review of Psychiatry, 9*(1), 99-110. https://doi.org/10.1080/09540269775628

Houghton, D. C., Mathew, A. S., Twohig, M. P., Saunders, S. M., Franklin, M. E., Compton, S. N., Neal-Barnett, A. M., & Woods, D. W. (2016). Trauma and trichotillomania: A tenuous relationship. *Journal of Obsessive-Compulsive and Related Disorders, 11*, 91-95. https://doi.org/10.1016/j.jocrd.2016.09.003

Hrehorów E, Salomon J, Matusiak L, Reich A, & Szepietowski J. C. (2012) Patients with psoriasis feel stigmatized. *Acta Dermato-venereologica, 92*(1), 67–72. https://doi.org/10.2340/00015555-1193

Hunter, H. J. A., Momen, S. E., & Kleyn, C. E. (2015). The impact of psychosocial stress on healthy skin. *Clinical and Experimental Dermatology, 40*(5), 540-546. https://doi.org/10.1111/ced.12582

Iliffe, L. L., & Thompson, A. R. (2019). Investigating the beneficial experiences of online peer support for those affected by alopecia: An interpretative phenomenological analysis using online interviews. *British Journal of Dermatology, 181*(5), 992-998. https://doi.org/10.1111/bjd.17998

Inzlicht, M., McKay, L., & Aronson, J. (2006). Stigma as ego depletion: How being the target of prejudice affects self-control. *Psychological Science, 17(*3), 262-269. https://doi.org/10.1111%2Fj.1467-9280.2006.01695.x

Jafferany, M., & Patel, A. (2019). Skin-picking disorder: A guide to diagnosis and management. *CNS drugs, 33*(4), 337-346. https://doi.org/10.1007/s40263-019-00621-7

Jagger, G. E., & Sterner, W. R. (2016). Excoriation: What counselors need to know about skin picking disorder. *Journal of Mental Health Counseling, 38*(4), 281-297. https://doi.org/10.17744/mehc.38.4.01

James, I. A., & Kendell, K. (1997). Unfinished processing in the emotional disorders: The Zeigarnik effect. *Behavioural and Cognitive Psychotherapy, 25*(4), 329-337. https://doi.org/10.1017/S1352465800018737

Jenkins, Z., Zavier, H., Phillipou, A., & Castle, D. (2019). Should skin picking disorder be considered a diagnostic category? A systematic review of the evidence. *Australian & New Zealand Journal of Psychiatry, 53*(9), 866-877. https://doi.org/10.1177/0004867419834347

Johnstone, L. (2018). Psychological formulation as an alternative to psychiatric diagnosis. Journal of *Humanistic Psychology, 58*(1), 30-46. https://doi.org/10.1177%2F0022167817722230

Jones, G., Keuthen, N., & Greenberg, E. (2018). Assessment and treatment of trichotillomania (hair pulling disorder) and excoriation (skin picking) disorder. *Clinics in Dermatology, 36*(6), 728-736. https://doi.org/10.1016/j.clindermatol.2018.08.008

Kaess, M., Parzer, P., Mattern, M., Plener, P. L., Bifulco, A., Resch, F., & Brunner, R. (2013). Adverse childhood experiences and their impact on frequency, severity, and the individual function of nonsuicidal self-injury in youth. *Psychiatry Research, 206*(2-3), 265-272. https://doi.org/10.1016/j.psychres.2012.10.012

Kahn, J. H., & Hessling, R. M. (2001). Measuring the tendency to conceal versus disclose psychological distress. *Journal of Social and Clinical Psychology, 20*(1), 41–65. https://doi.org/10.1521/jscp.20.1.41.22254

Kapp, S. K., Steward, R., Crane, L., Elliot, D., Elphick, C., Pellicano, E., & Russel, G. (2019). 'People should be allowed to do what they like': Autistic adults' views and experiences of stimming. *Autism, 23*(7), 1782-1792. https://doi.org/10.1177/1362361319829628

Kasar, N., & Yurteri, N. (2020). Atomoxetine Induced Skin Picking: A Case Report. *Clinical Neuropharmacology, 43*(2), 46-47. https://doi.org/10.1097/WNF.0000000000000379

Kaufman, G. (1996). *The psychology of shame: Theory and treatment of shame-based syndromes* (2nd ed.). Springer Publishing Company.

Kellett, S. (2002). Shame-fused acne: A biopsychosocial conceptualisation and treatment rationale. In P. Gilbert 7 J. Miles (Eds.), *Body shame: Conceptualisation, research and treatment* (pp. 135-154). Routledge.

Kellett, S., & Gilbert, P. (2001). Acne: A biopsychosocial and evolutionary perspective with a focus on shame. *British Journal of Health Psychology, 6*(1), 1-24. https://doi.org/10.1348/135910701169025

Kent, G., & Thompson, A. R. (2002). The development and maintenance of shame in disfigurement: Implications for treatment. In P. Gilbert & J. Miles (Eds*.), Body Shame: Conceptualisation, Research and Treatment* (pp. 103-116). Routledge.

Keuthen, N. J., Deckersbach, T., Wilhelm, S., Engelhard, I., Forker, A., O'Sullivan, R. L., Jenike, M. A. & Baer, L. (2001a). The skin picking impact scale (SPIS): Scale development and psychometric analyses. *Psychosomatics, 42*(5), 397-403. https://doi.org/10.1176/appi.psy.42.5.397

Keuthen, N. J., Deckersbach, T., Wilhelm, S., Hale, E., Fraim, C., Baer, L., O'Sullivan, R. & Jenike, M. A. (2000). Repetitive skin-picking in a student population and comparison with a sample of self-injurious skin-pickers*. Psychosomatics, 41*(3), 210-215. https://doi.org/10.1176/appi.psy.41.3.210

Keuthen, N. J., Koran, L. M., Aboujaoude, E., Large, M. D., & Serpe, R. T. (2010). The prevalence of pathologic skin picking in US adults. *Comprehensive Psychiatry, 51*(2), 183-186. https://doi.org/10.1016/j.comppsych.2009.04.003

Keuthen, N. J., Rothbaum, B. O., Falkenstein, M. J., Meunier, S., Timpano, K. R., Jenike, M. A., & Welch, S. S. (2011). DBT-enhanced habit reversal treatment for trichotillomania: 3-and 6-month follow-up results. *Depression and Anxiety, 28*(4), 310-313. https://doi.org/10.1002/da.20778

Keuthen, N. J., Wilhelm, S., Deckersbach, T., Engelhard, I. M., Forker, A. E., Baer, L., & Jenike, M. A. (2001b). The Skin Picking Scale: scale construction and psychometric analyses. *Journal of Psychosomatic Research, 50*(6), 337-341. https://doi.org/10.1016/S0022-3999(01)00215-X

Kohut, H. (1984). *How does analysis cure?* The University of Chicago Press.

Koo, J., & Lebwohl, A. (2001). Psychodermatology: The mind and skin connection. *American Family Physician, 64*(11), 1873-1879.

Kurzban, R., Leary, M. R. (2001). Evolutionary origins of stigmatization: The functions of social exclusion. *Psychological Bulletin, 127*(2), 187–208. https://psycnet.apa.org/buy/2001-16969-001

Lazare, A. (1987). Shame and humiliation in the medical encounter. *Archives of Internal Medicine, 147*(9), 1653-1658. https://doi.org/10.1001/archinte.1987.00370090129021

Legard, R., Keegan, J., & Ward, K. (2003). In-depth interviews. In J. Ritchie, J. Lewis (Eds), *Qualitative research practice: A guide for social science students and researchers* (pp. 138-169). SAGE Publications.

Leppink, E. W., Odlaug, B. L., Lust, K., Christenson, G., & Grant, J. E. (2016). The young and the stressed: Stress, impulse control, and health in college students. *The Journal of Nervous and Mental Disease, 204*(12), 931-938. https://doi.org/10.1097/NMD.0000000000000586

Lewis, C., & Fabos, B. (2005). Instant messaging, literacies, and social identities. *Reading Research Quarterly, 40*(4), 470-501. https://doi.org/10.1598/RRQ.40.4.5

Lochner, C., Simeon, D., Niehaus, D. J. H., & Stein, D. J. (2002). Trichotillomania and skin picking: A phenomenological comparison. *Depression and Anxiety, 15*(2), 83-86. https://doi.org/10.1002/da.10034

Lowell, M. A., & Meader, L. L. (2005). My body, your body: Speaking the unspoken between the thin therapist and the eating-disordered patient. *Clinical Social Work Journal, 33*(3), 241-257. http://doi.org/10.1007/s10615-005-4941-x

Lincoln, Y. S., & Guba, E. G. (1985). Establishing trustworthiness. *Naturalistic Inquiry, 289*(331), 289-327.

Lunnay, B., Borlagdan, J., McNaughton, D., & Ward, P. (2015). Ethical use of social media to facilitate qualitative research. *Qualitative Health Research, 25*(1), 99-109. https://doi.org/10.1177%2F1049732314549031

Machado, M. O., Köhler, C. A., Stubbs, B., Nunes-Neto, P. R., Koyanagi, A., Quevedo, J., Soares, J. C., Hyphantis, T. N., Marazziti, D., Maes, M., Stein, D. J., & Carvalho, A. F. (2018). Skin picking disorder: prevalence, correlates, and associations with quality of life in a large sample. *CNS spectrums, 23*(5), 311-320. https://doi.org/10.1017/S1092852918000871

Mackenzie, C. S., Gekoski, W. L., & Knox, V. J. (2006). Age, gender, and the underutilization of mental health services: The influence of help-seeking attitudes. *Aging and Mental Health, 10*(6), 574-582. https://doi.org/10.1080/13607860600641200

Mackenzie, K. (2018). Stereotypic movement disorders. *Seminars in Pediatric Neurology, 25,* 19-24. https://doi.org/10.1016/j.spen.2017.12.004

Maestripieri, D., Schino, G., Aureli, F., & Troisi, A. (1992). A modest proposal: displacement activities as an indicator of emotions in primates. *Animal Behaviour, 44*(5), 967-979. https://doi.org/10.1016/S0003-3472(05)80592-5

Magin, P., Adams, J., Heading, G., & Pond, D. (2011). 'Perfect skin', the media and patients with skin disease: a qualitative study of patients with acne, psoriasis and atopic eczema. *Australian Journal of Primary Health, 17*(2), 181-185. https://doi.org/10.1071/PY10047

Malayala S V, Rehman H, Vasireddy D (January 27, 2021) Dermatillomania: A Case Report and Literature Review. *Cureus 13*(1), Article e12932. https://doi.org/10.7759/cureus.12932

Malterud, K., Siersma, V. D., & Guassora, A. D. (2015). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research, 26*(13), 1753-1760. https://doi.org/10.1177%2F1049732315617444

Mancini, M., & Esposito, C. M. (2021). Lived body and the Other's gaze: a phenomenological perspective on feeding and eating disorders. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity.* Online publication. https://doi.org/10.1007/s40519-020-01103-2

Manderson, L., Bennett, E., & Andajani-Sutjahjo, S. (2006). The social dynamics of the interview: Age, class, and gender. *Qualitative Health Research, 16*(10), 1317-1334. https://doi.org/10.1177%2F1049732306294512

Maraz, A., Hende, B., Urbán, R., & Demetrovics, Z. (2017). Pathological grooming: Evidence for a single factor behind trichotillomania, skin picking and nail biting. *PloS one, 12*(9), e0183806. https://doi.org/10.1371/journal.pone.0183806

Marques, L., Weingarden, H. M., LeBlanc, N. J., Siev, J., & Wilhelm, S. (2011). The relationship between perceived social support and severity of body dysmorphic disorder symptoms: The role of gender. *Brazilian Journal of Psychiatry, 33*(3), 238-244. https://doi.org/10.1590/S1516-44462011005000010

Martinson, A. A., Nangle, D. W., Boulard, N., & Sigmon, S. T. (2011). Old habits die hard: Treating a woman with a 20-year severe case of skin picking disorder. *Clinical Case Studies, 10*(6), 411-426. https://doi.org/10.1177%2F1534650111428508

Mason-Schrock, D. (1996). Transsexuals' narrative construction of the "true self". *Social Psychology Quarterly, 59*(3), 176-192. https://doi.org/10.2307/2787018

Maxwell, J. A. (2012). *A realist approach for qualitative research*. SAGE Publications.

McAuliffe, D. (2003). Challenging methodological traditions: Research by email. *The Qualitative Report, 8*(1), 57-69. https://doi.org/10.46743/2160-3715/2003.1898

McCoyd, J. L. M., & Kearson, T. S. (2006). Conducting intensive interviews using email: A serendipitous comparative opportunity. *Qualitative Social Work, 5*(3), 389-406. https://doi.org/10.1177%2F1473325006067367

McGuire, J. F., Kugler, B. B., Park, J. M., Horng, B., Lewin, A. B., Murphy, T. K., & Storch, E. A. (2012). Evidence-based assessment of compulsive skin picking, chronic tic disorders and trichotillomania in children. *Child Psychiatry & Human Development, 43*, 855-883. https://doi.org/10.1007/s10578-012-0300-7

Mohiyeddini, C., & Semple, S. (2013). Displacement behaviour regulates the experience of stress in men. *Stress, 16*(2), 163-171. https://doi.org/10.3109/10253890.2012.707709

Mohiyeddini, C., Bauer, S., & Semple, S. (2013a). Displacement behaviour is associated with reduced stress levels among men but not women. *PloS one, 8*(2), e56355. https://doi.org/10.1371/journal.pone.0056355

Mohiyeddini, C., Bauer, S., & Semple, S. (2013b). Public self-consciousness moderates the link between displacement behaviour and experience of stress in women. *Stress, 16*(4), 384-392. https://doi.org/10.3109/10253890.2012.755171

Möller-Leimkühler, A. M. (2002). Barriers to help-seeking by men: a review of sociocultural and clinical literature with particular reference to depression. *Journal of Affective Disorders, 71*(1-3), 1-9. https://doi.org/10.1016/S0165-0327(01)00379-2

Monro, F., & Huon, G. (2005). Media-portrayed idealized images, body shame, and appearance anxiety. *International Journal of Eating Disorders, 38*(1), 85-90. https://doi.org/10.1002/eat.20153

Montagna, W. & Parakkal, P. F. (2012). *The structure and function of skin* (3rd ed.). Academic Press.

Mooring, M. S., Blumstein, D. T., & Stoner, C. J. (2004). The evolution of parasite-defence grooming in ungulates. *Biological Journal of the Linnean Society, 81*(1), 17-37. https://doi.org/10.1111/j.1095-8312.2004.00273.x

Morelen, D., Jacob, M. L., Suveg, C., Jones, A., & Thomassin, K. (2013). Family emotion expressivity, emotion regulation, and the link to psychopathology: Examination across race. *British Journal of Psychology, 104*(2), 149-166. https://doi.org/10.1111/j.2044-8295.2012.02108.x

Moritz, S., Fricke, S., Treszl, A., & Wittekind, C. E. (2012). Do it yourself! Evaluation of self-help habit reversal training versus decoupling in pathological skin picking: A pilot study. *Journal of Obsessive-Compulsive and Related Disorders, 1(*1), 41-47. https://doi.org/10.1016/j.jocrd.2011.11.001

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250-260. https://doi.org/10.1037/0022-0167.52.2.250

Mrazek, M. D., Chin, J. M., Schmader, T., Hartson, K. A., Smallwood, J., & Schooler, J. W. (2011). Threatened to distraction: Mind-wandering as a consequence of stereotype threat. *Journal of Experimental Social Psychology, 47*(6), 1243-1248. https://doi.org/10.1016/j.jesp.2011.05.011

Murphy, Y. E., & Flessner, C. A. (2017). An investigation of impulsivity in young adults exhibiting body-focused repetitive behaviors. *Journal of Obsessive-Compulsive and Related Disorders, 12*, 34-40. https://doi.org/10.1016/j.jocrd.2016.12.002

Nadelson, T. (1978). A person's boundaries: A meaning of skin disease. *Cutis, 21*(1), 90-93.

Nakell, S. (2015). A healing herd: Benefits of a psychodynamic group approach in treating body-focused repetitive behaviors. *International Journal of Group Psychotherapy, 65*(2), 295-306. https://doi.org/10.1521/ijgp.2015.65.2.295

Nemeroff, C. B., Weinberger, D., Rutter, M., MacMillan, H. L., Bryant, R. A., Wessely, S., Stein, D. J., Pariante, C. M., Seemüller, F., Berk, M., Malhi, G. S., Preisig, M., Brüne, M., & Lysaker, P. (2013). DSM-5: A collection of psychiatrist views on the changes, controversies, and future directions. *BMC Medicine, 11*(1), 202. https://doi.org/10.1186/1741-7015-11-202

Neville, S., Adams, J. & Cook, C. (2016). Using internet-based approaches to collect qualitative data from vulnerable groups: Reflections from the field. *Contemporary Nurse, 52*(6), 657-668. https://doi.org/10.1080/10376178.2015.1095056

Neziroglu, F., Rabinowitz, D., Breytman, A., & Jacofsky, M. (2008). Skin picking phenomenology and severity comparison. *Journal of Clinical Psychiatry, 10*(4), 306-312. https://dx.doi.org/10.4088%2Fpcc.v10n0406

Noble, C. M., Gnilka, P. B., Ashby, J. S., & McLaulin, S. E. (2017). Perfectionism, shame, and trichotillomania symptoms in clinical and nonclinical samples. *Journal of Mental Health Counseling, 39*(4), 335-350. https://doi.org/10.17744/mehc.39.4.05

Nock, M. K., & Favazza, A. R. (2009). Nonsuicidal self-injury: Definition and classification. In M. K.

Nock (Ed.), *Understanding nonsuicidal self-injury: Origins, assessment, and treatment* (pp. 9–18). American Psychological Association. https://doi.org/10.1037/11875-001

O'Connor, K., Brisebois, H., Brault, M., Robillard, S., & Loiselle, J. (2003). Behavioral activity associated with onset in chronic tic and habit disorder. *Behaviour Research and Therapy, 41*(2), 241-249. https://doi.org/10.1016/S0005-7967(02)00051-7

O'Sullivan, R. L., Phillips, K. A., Keuthen, N. J., & Wilhelm, S. (1999). Near-fatal skin picking from delusional body dysmorphic disorder responsive to fluvoxamine. *Psychosomatics, 40*(1), 79-81.

Oakley, A. (1981). Interviewing women: A contradiction in terms. In H. Roberts (Ed.), *Doing Feminist Research* (pp. 30 – 61). Routledge.

Odlaug, B. L., & Grant, J. E. (2007). Childhood-onset pathologic skin picking: Clinical characteristics and psychiatric comorbidity. *Comprehensive Psychiatry, 48*(4), 388-393. https://doi.org/10.1016/j.comppsych.2007.03.007

Odlaug, B. L., & Grant, J. E. (2008a). Clinical characteristics and medical complications of pathologic skin picking. *General Hospital Psychiatry, 30*(1), 61-66. https://doi.org/10.1016/j.genhosppsych.2007.07.009

Odlaug, B. L., & Grant, J. E. (2008b). Trichotillomania and pathologic skin picking: Clinical comparison with an examination of comorbidity. *Annals of Clinical Psychiatry, 20*(2), 57-63. http://dx.doi.org/10.1080/10401230802017027

Odlaug, B. L., & Grant, J. E. (2010). Pathologic skin picking. *American Journal of Drug and Alcohol Abuse, 36*(5), 296-303. https://doi.org/10.3109/00952991003747543

Odlaug, B. L., Lust, K., Schreiber, L. R., Christenson, G., Derbyshire, K., & Grant, J. E. (2013). Skin picking disorder in university students: health correlates and gender differences. *General Hospital Psychiatry, 35*(2), 168-173. https://doi.org/10.1016/j.genhosppsych.2012.08.006

Ólafsson, R. P., Emmelkamp, P. M., Ólason, D. P., & Kristjánsson, Á. (2020). Disgust and Contamination Concerns: The Mediating Role of Harm Avoidance and Incompleteness. *International Journal of Cognitive Therapy, 13*, 251-270. https://doi.org/10.1007/s41811-020-00076-5

Oliffe, J., Thorne, S. (2007). Men, masculinities and prostate cancer: Australian and Canadian patient perspectives of communication with male physicians. *Qualitative Health Research, 17*(2), 149-161. https://doi.org/10.1177%2F1049732306297695

Oliveira, E. C. B., Leppink, E. W., Derbyshire, K. L., & Grant, J. E. (2015). Excoriation disorder: Impulsivity and its clinical associations. *Journal of Anxiety Disorders, 30*, 19-22. https://doi.org/10.1016/j.janxdis.2014.12.010

Ong, J., Clarke, A., White, P., Johnson, M., Withey, S., & Butler, P. E. (2007). Does severity predict distress? The relationship between subjective and objective measures of appearance and psychological adjustment, during treatment for facial lipoatrophy. *Body Image, 4*(3), 239-248. https://doi.org/10.1016/j.bodyim.2007.05.003

Özten, E., Sayar, G. H., Eryılmaz, G., Kağan, G., Işık, S., & Karamustafalıoğlu, O. (2015). The relationship of psychological trauma with trichotillomania and skin picking. *Neuropsychiatric Disease and Treatment, 11*, 1203-1210. https://doi.org/10.2147/NDT.S79554

Parkinson, H. J. (2015, April 30). *Explosive! Behind the internet's fascination with pimple popping, zit zapping and squeezing cysts.* The Guardian. Retrieved February 20, 2021, from https://www.theguardian.com/technology/2015/apr/30/cyst-popping-explosion-pimple-popping-extraction-behind-community

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Sage.

Pearce, S. (2014). DSM-5 and the rise of the diagnostic checklist. *Journal of Medical Ethics, 40*(8), 515-516. http://dx.doi.org/10.1136/medethics-2013-101933

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* W W Norton & Co.

Peel, E., Parry, O., Douglas, M., & Lawton, J. (2006). "It's no skin off my nose": why people take part in qualitative research. *Qualitative Health Research, 16*(10), 1335-1349. https://doi.org/10.1177%2F1049732306294511

Pélissier, M-C., & O'Connor, K. (2004). Cognitive-behavioral treatment of trichotillomania, targeting perfectionism. *Clinical Case Studies, 3*(1), 57-69. https://doi.org/10.1177%2F1534650103258973

Penzel, F. (2003). *The hair-pulling problem: A complete guide to trichotillomania*. Oxford University Press.

Perlman, K. (2019). The Relationality of Skin: An Introduction to the Essays of Summers, Lothstein, and Simha-Alpern. *Psychoanalytic Perspectives, 16*(1), 30-37. https://doi.org/10.1080/1551806X.2018.1554955

Perrykkad, K., & Hohwy, J. (2020). Fidgeting as self-evidencing: A predictive processing account of non-goal-directed action. *New Ideas in Psychology, 56*, 100750. https://doi.org/10.1016/j.newideapsych.2019.100750

Philips, K. A. & Diaz, S. F. (1997). Gender differences in body dysmorphic disorder. *Journal of Nervous & Mental Disease, 185*(9), 570-577.

Pilgrim, D. (2014). Some implications of critical realism for mental health research. *Social Theory & Health, 12*(1), 1-21. https://doi.org/10.1057/sth.2013.17

Pinto, A., Dargani, N., Wheaton, M. G., Cervoni, C., Rees, C. S., & Egan, S. J. (2017). Perfectionism in obsessive-compulsive disorder and related disorders: What should treating clinicians know? *Journal of Obsessive-Compulsive and related disorders, 12*, 102-108. https://doi.org/10.1016/j.jocrd.2017.01.001

Polce-Lynch, M., Myers, B. J., Kilmartin, C. T., Forssmann-Falck, R., & Kliewer, W. (1998). Gender and age patterns in emotional expression, body image, and self-esteem: A qualitative analysis. *Sex Roles, 38*, 1025-1048. https://doi.org/10.1023/A:1018830727244

Potenza, M. N. (2006). Should addictive disorders include non-substance-related conditions? *Addiction, 101*(s1), 142-151. https://doi.org/10.1111/j.1360-0443.2006.01591.x

Pozza, A., Giaquinta, N., & Dèttore, D. (2016). Borderline, avoidant, sadistic personality traits and emotion dysregulation predict different pathological skin picking subtypes in a community sample. *Neuropsychiatric Disease and Treatment, 12,* 1861-1867. https://dx.doi.org/10.2147%2FNDT.S109162

Prochwicz, K., Kałużna-Wielobób, A., & Kłosowska, J. (2016). Skin picking in a non-clinical sample of young Polish adults. Prevalence and characteristics. *Comprehensive Psychiatry, 71*, 77-85. https://doi.org/10.1016/j.comppsych.2016.08.013

ProjectKillGeorge. (2012, March 2). *BIGGEST CYST ON THE PLANET | Operation "Kill George"* [YouTube video]. YouTube. Retrieved February 20, 2021, from https://www.youtube.com/watch?v=r4zX892XOaw&feature=emb_title

Prosser, J. (2001). Skin memories. In S. Ahmed & J. Stacey (Eds.), *Thinking through the skin (pp.* 52-68), Routledge.

Reddy, B., Das, S., & Guruprasad, S. (2018). A case of clozapine-induced skin picking behaviour. *General Psychiatry, 31*(2), e000012. https://dx.doi.org/10.1136%2Fgpsych-2018-000012

Rehm, I. C., Nedeljkovic, M., Thomas, A., & Moulding, R. (2015). The role of cognitions and beliefs in trichotillomania: A qualitative study using interpretative phenomenological analysis. *Behaviour Change, 32*(4), 209-230. https://doi.org/10.1017/bec.2015.11

Ricketts, E. J., Snorrason, Í., Kircanski, K., Alexander, J. R., Thamrin, H., Flessner, C. A., Franklin, M. E., Piacentini, J., & Woods, D. W. (2018). A latent profile analysis of age of onset in pathological skin picking. *Comprehensive Psychiatry, 87,* 46-52. https://doi.org/10.1016/j.comppsych.2018.08.011

Roberts, S., O'Connor, K., & Bélanger, C. (2013). Emotion regulation and other psychological models for body-focused repetitive behaviors. *Clinical Psychology Review, 33*(6), 745-762. https://doi.org/10.1016/j.cpr.2013.05.004

Roberts, S., O’Connor, K., Aardema, F., & Belanger, C. (2015). The impact of emotions on body focussed repetitive behaviours: Evidence from a non-treatment seeking sample. *Journal of*

Behaviour Therapy and Experimental Psychiatry, 46, 189-197. https://doi.org/10.1016/j.jbtep.2014.10.007

Rogers, C. (1951). *Client-centered therapy: Its current practice, implications and theory*. Constable.

Rosen, J. C. (1995). The nature of body dysmorphic disorder and treatment with cognitive behavior therapy. *Cognitive and Behavioral Practice, 2*(1), 143-166. https://doi.org/10.1016/S1077-7229(05)80008-2

Rossi, E., Castellini, G., Cassioli, E., Sensi, C., Mancini, M., Stanghellini, G., & Ricca, V. (2021). The role of embodiment in the treatment of patients with anorexia and bulimia nervosa: a 2-year follow-up study proposing an integration between enhanced cognitive behavioural therapy and a phenomenological model of eating disorders. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity.* Online publication. https://doi.org/10.1007/s40519-021-01118-3

Rubin, H. J., & Rubin, I. S. (2012). *Qualitative interviewing: The art of hearing data* (3rd ed.). SAGE Publications.

Schienle, A., Übel, S., & Wabnegger, A. (2018a). Visual symptom provocation in skin picking disorder: an fMRI study. *Brain Imaging and Behavior, 12,* 1504-1512. https://doi.org/10.1007/s11682-017-9792-x

Schienle, A., Zorjan, S., Übel, S., & Wabnegger, A. (2018b). Prediction of automatic and focused skin picking based on trait disgust and emotion dysregulation. *Journal of Obsessive-Compulsive and Related Disorders, 16,* 1-5. https://doi.org/10.1016/j.jocrd.2017.10.006

Schooler, J. W., Smallwood, J., Christoff, K., Handy, T. C., Reichle, E. D., & Sayette, M. A. (2011). Meta-awareness, perceptual decoupling and the wandering mind. *Trends in Cognitive Sciences, 15*(7), 319-326. https://doi.org/10.1016/j.tics.2011.05.006

Schuck, K., Keijsers, G. P. J., & Rinck, M. (2011). The effects of brief cognitive-behaviour therapy for pathological skin picking: A randomized comparison to wait-list control. *Behaviour Research and Therapy, 49*(1), 11-17. https://doi.org/10.1016/j.brat.2010.09.005

Schumer, M. C., Bartley, C. A., & Bloch, M. H. (2016). Systematic review of pharmacological and behavioral treatments for skin picking disorder. *Journal of Clinical Psychopharmacology, 36*(2), 147-152. https://doi.org/10.1097/JCP.0000000000000462

Senra, M. S., & Wollenberg, A. (2014). Psychodermatological aspects of atopic dermatitis. *British Journal of Dermatology, 170*(s1), 38-43. https://doi.org/10.1111/bjd.13084

Seppala, E., Rossomando, T., & Doty, J. R. (2013). Social connection and compassion: Important predictors of health and well-being. *Social Research: An International Quarterly, 80*(2), 411-430.

Seymour, W. S. (2001). In the flesh or online? Exploring qualitative research methodologies. *Qualitative Research, 1*(2), 147-168. https://doi.org/10.1177%2F146879410100100203

Shah, K. N., & Fried, R. G. (2006). Factitial dermatoses in children. *Current Opinion in Pediatrics, 18*(4), 403-409. https://doi.org/10.1097/01.mop.0000236390.41462.39

Shapiro, S. L., Carlson, L. E., Astin, J. A., & Freedman, B. (2006). Mechanisms of mindfulness. *Journal of Clinical Psychology, 62*(3), 373-386. https://doi.org/10.1002/jclp.20237

Shenefelt, P. D. (2010). Psychological interventions in the management of common skin conditions. *Psychology Research and Behavior Management, 3,* 51. https://doi.org/10.2147/PRBM.S7072

Shepherd, L., Reynolds, D. P., Turner, A., O'Boyle, C. P., & Thompson, A. R. (2019). The role of psychological flexibility in appearance anxiety in people who have experienced a visible burn injury. *Burns, 45*(4), 942-949. https://doi.org/10.1016/j.burns.2018.11.015

Shusterman, A., Feld, L., Baer, L., & Keuthen, N. (2009). Affective regulation in trichotillomania: Evidence from a large-scale internet survey. *Behaviour Research and Therapy, 47*(8), 637-644. https://doi.org/10.1016/j.brat.2009.04.004

Siev, J., Reese, H. E., Timpano, K., & Wilhelm, S. (2012). Assessment and treatment of pathological skin picking. In J. E. Grant & M. N. Potenza (Eds.), *The Oxford handbook of impulse control disorders*. Oxford University Press. https://doi.org/10.1093/oxfordhb/9780195389715.013.0103

Siwiec, S., & McBride, D. L. (2016). Emotional regulation cycles in trichotillomania (hair-pulling disorder) across subtypes. *Journal of Obsessive-Compulsive and Related Disorders, 10*, 84-90. https://doi.org/10.1016/j.jocrd.2016.06.003

Simeon, D., Stein, D. J., Gross, S., Islam, N., Schmeidler, J., & Hollander, E. (1997). A double-blind trial of fluoxetine in pathologic skin picking. *The Journal of Clinical Psychiatry, 58*(8), 341-347. https://www.psychiatrist.com/jcp/ocd/double-blind-trial-fluoxetine-pathologic-skin-picking/

Singer, H. S. (2009). Motor stereotypies. *Seminars in Pediatric Neurology, 16*(2), 77-81. https://doi.org/10.1016/j.spen.2009.03.008

Skårderud, F. (2007). Shame and pride in anorexia nervosa: A qualitative descriptive study. *European Eating Disorders Review, 15*(2), 81-97. https://doi.org/10.1002/erv.774

Slepian, M. L., Chun, J. S., & Mason, M. F. (2017). The experience of secrecy. *Journal of Personality and Social Psychology, 113*(1), 1-33. https://psycnet.apa.org/doi/10.1037/pspa0000085

Smith, J. A., & Shinebourne, P. (2012). Interpretative phenomenological analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbooks in psychology®. APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological* (p. 73–82). American Psychological Association. https://doi.org/10.1037/13620-005

Snorrason, Í. (2016). *Examining heightened sense of incompleteness as a candidate endophenotypic marker for skin picking disorder* (Publication No. 1310) [Doctoral Dissertation, The University of Wisconsin-Milwaukee]. UWM Digital Commons. https://dc.uwm.edu/etd/1310

Snorrason, Í., Belleau, E. L., & Woods, D. W. (2012). How related are hair pulling disorder (trichotillomania) and skin picking disorder? A review of evidence for comorbidity, similarities and shared etiology. *Clinical Psychology Review, 32*(7), 618-629. https://doi.org/10.1016/j.cpr.2012.05.008

Snorrason, Í., Smári, J., & Ólafsson, R. P. (2010). Emotion regulation in pathological skin picking: Findings from a non-treatment seeking sample. *Journal of Behavior Therapy and Experimental Psychiatry, 41*(3), 238-245. https://doi.org/10.1016/j.jbtep.2010.01.009

Snorrason, Í., & Woods, D. W. (2014). Hair pulling, skin picking, and other body-focused repetitive behaviors. In E.Storch & D. McKay (Eds.) *Obsessive-compulsive disorder and its spectrum: A life-span approach* (pp. 163-184). American Psychological Association.

Solley, K., & Turner, C. (2018). Prevalence and correlates of clinically significant body-focused repetitive behaviors in a non-clinical sample. *Comprehensive Psychiatry, 86*, 9-18. https://doi.org/10.1016/j.comppsych.2018.06.014

Starcke, K., & Brand, M. (2012). Decision making under stress: a selective review. *Neuroscience & Biobehavioral Reviews, 36*(4), 1228-1248. https://doi.org/10.1016/j.neubiorev.2012.02.003

Stein, D. J. (2019). Stereotypic Movement Disorder. In L. F. Fontenelle & M. Yücel (Eds.), *A Transdiagnostic Approach to Obsessions, Compulsions and Related Phenomena* (pp. 376-382). Cambridge University Press.

Stein, D. J., Grant, J. E., Franklin, M. E., Keuthen, N., Lochner, C., Singer, H. S., & Woods, D. W. (2010). Trichotillomania (hair pulling disorder), skin picking disorder, and stereotypic movement disorder: Toward DSM-V. *Depression and Anxiety, 27*(6), 611-626. https://doi.org/10.1002/da.20700

Storch, E. A., Milsom, V. A., Merlo, L. J., Larson, M., Geffken, G. R., Jacob, M. L., Murphy, T. K., & Goodman, W. K. (2008). Insight in pediatric obsessive-compulsive disorder: Associations with clinical presentation. *Psychiatry Research, 160*(2), 212-220. https://doi.org/10.1016/j.psychres.2007.07.005

Strathern, A. (1975). Why is Shame on the Skin? *Ethnology, 14*(4), 347-356. https://doi.org/10.2307/3773236

Strawbridge, S. & Woolfe, R., (2003). Counselling psychology in context. In R. Woolfe, W. Dryden, & S. Strawberry (Eds.), *Handbook of Counselling Psychology* (2nd Ed, pp. 3-21), SAGE Publications.

Sukhodolsky, D. G., Scahill, L., Gadow, K. D., Arnold, L. E., Aman, M. G., McDougle, C. J., McCracken, J. T., Tiernet, E., Williams White, S., Lecavalier, L., & Vitiello, B. (2008). Parent-rated anxiety symptoms in children with pervasive developmental disorders: Frequency and association with core autism symptoms and cognitive functioning. *Journal of Abnormal Child Psychology, 36*, 117-128. https://doi.org/10.1007/s10802-007-9165-9

Summers, B. J., Matheny, N. L., & Cougle, J. R. (2017). ‘Not just right’ experiences and incompleteness in body dysmorphic disorder. *Psychiatry Research, 247*, 200 –207. https://doi.org/10.1016/j.psychres.2016.11.038

Sündermann, O., Wheatley, J., & Veale, D. (2016). ‘If you have good skin, you are god. If you have bad skin, you are a piece of rubbish’. Mastery of shame and anger in treatment-resistant body dysmorphic disorder: a single case study. *the Cognitive Behaviour Therapist*, *9*, e13. https://doi.org/10.1017/S1754470X16000118

Taylor, S., McKay, D., Crowe, K. B., Abramowitz, J. S., Conelea, C. A., Calamari, J. E., & Sica, C. (2014). The sense of incompleteness as a motivator of obsessive-compulsive symptoms: An empirical analysis of concepts and correlates. *Behavior Therapy, 45*(2), 254-262. https://doi.org/10.1016/j.beth.2013.11.004

Teng, E. J., Woods, D. W., & Twohig, M. P. (2006). Habit reversal as a treatment for chronic skin picking: A pilot investigation. *Behavior Modification, 30*(4), 411-422. https://doi.org/10.1177%2F0145445504265707

Teng, E. J., Woods, D. W., Twohig, M. P., & Marcks, B. A. (2002). Body-focused repetitive behavior problems: Prevalence in a nonreferred population and differences in perceived somatic activity. *Behavior Modification, 26*(3), 340-360. https://doi.org/10.1177%2F0145445502026003003

Thompson, A., & Kent, G. (2001). Adjusting to disfigurement: Processes involved in dealing with being visibly different. *Clinical Psychology Review, 21*(5), 663-682. https://doi.org/10.1016/S0272-7358(00)00056-8

Thompson, A. R., & Montgomery, K. (2018). Stress and more stress: The importance in skin disease of worrying about what others think. *British Association of Dermatologists, 178*(4), 821-822. https://doi.org/10.1111/bjd.16469

Thompson, A. R., & Russo, K. (2012). Ethical dilemmas for clinical psychologists in conducting qualitative research. *Qualitative Research in Psychology, 9*(1), 32-46. https://doi.org/10.1080/14780887.2012.630636

Tice, D. M., Bratslavsky, E., & Baumeister, R. F. (2001). Emotional distress regulation takes precedence over impulse control: If you feel bad, do it!. *Journal of Personality and Social Psychology, 80*(1), 53-67. https://psycnet.apa.org/doi/10.1037/0022-3514.80.1.53

Tiggemann, M. (20111). Sociocultural perspectives on human appearance and body image. In T. F. Cash & L. Smolak (Eds.), *Body Image: A handbook of science, practice and prevention* (2nd ed., pp. 12-19). The Guilford Press.

Troisi, A. (2002). Displacement activities as a behavioral measure of stress in nonhuman primates and human subjects. *Stress, 5*(1), 47-54. https://doi.org/10.1080/102538902900012378

Tucker, B. T. P., Woods, D. W., Flessner, C. A., Franklin, S. A., & Franklin, M. E. (2011). The skin picking impact project: Phenomenology, interference, and treatment utilization of pathological skin picking in a population-based sample. *Journal of Anxiety Disorders, 25*(1), 88-95. https://doi.org/10.1016/j.janxdis.2010.08.007

Turner, T.S. (2012). The social skin. *Journal of Ethnographic Theory, 2*(2), 486-504. https://www.journals.uchicago.edu/doi/pdf/10.14318/hau2.2.026

Twenge, J. M., & Baumeister, R. F. (2005). Social exclusion increases aggression and self-defeating behavior while reducing intelligent thought and prosocial behavior. In D. Abrams, M. A.

Hogg, & J. M. Marques (Eds.), *Social psychology of inclusion and exclusion* (pp. 27-46). Psychology Press.

Twohig, M. P., Hayes, S. C., & Masuda, A. (2006). A preliminary investigation of acceptance and commitment therapy as a treatment for chronic skin picking*. Behaviour Research and Therapy, 44*(10), 1513-1522. https://doi.org/10.1016/j.brat.2005.10.002

Twohig, M. J. P., Woods, D. W., Marcks, B. A., & Teng, E. J. (2003). Evaluating the efficacy of habit reversal: Comparison to a placebo control. *Journal of Clinical Psychiatry, 64*, 40-48. Retrieved from https://www.psychiatrist.com/jcp/depression/evaluating-efficacy-habit-reversal-comparison-placebo/

Ussher, J. M. (1999). Eclecticism and methodological pluralism: The way forward for feminist research. *Psychology of Women Quarterly, 23*, 41-46. https://doi.org/10.1111%2Fj.1471-6402.1999.tb00339.x

Veale, D. (2004). Advances in a cognitive behavioural model of body dysmorphic disorder. *Body image, 1*(1), 113-125. https://doi.org/10.1016/S1740-1445(03)00009-3

Walther, M. R., Flessner, C. A., Conelea, C. A., & Woods, D. W. (2009). The Milwaukee Inventory for the Dimensions of Adult Skin Picking (MIDAS): Initial development and psychometric properties. *Journal of Behavior Therapy and Experimental Psychiatry, 40*(1), 127-135. https://doi.org/10.1016/j.jbtep.2008.07.002

Wells, A., Clark, D. M., Salkovskis, P., Ludgate, J., Hackmann, A., & Gelder, M. (1995). Social phobia: The role of in-situation safety behaviors in maintaining anxiety and negative beliefs. *Behavior Therapy, 26*(1), 153-161. https://doi.org/10.1016/S0005-7894(05)80088-7

Whitaker, C., Stevelink, S., & Fear, N. (2017). The use of Facebook in recruiting participants for health research purposes: A systematic review. *Journal of Medical Internet Research, 19*(8), e290. https://doi.org/10.2196/jmir.7071

Wilhelm, S., Keuthen, N. J., Deckersbach, T., Engelhard, I. M., Forker, A. E., Baer, O'Sullivan, R. L., & Jenike, M. A. (1999). Self-injurious skin picking: Clinical characteristics and comorbidity. *Journal of Clinical Psychiatry, 60*(7), 454-459. https://www.psychiatrist.com/jcp/medical/comorbidity/self-injurious-skin-picking-clinical-characteristics/

Willson, R., Veale, D., Freeston, M. (2016). Imagery rescripting for body dysmorphic disorder: A multiple-baseline single-case experimental design, *Behaviour Therapy, 47*(2), 248-61. https://doi.org/10.1016/j.beth.2015.08.006

Winnicott, D. W. (1945). Primitive-emotional development. *The International Journal of Psychoanalysis, 26*, 137–143. https://www.pep-web.org/document.php?id=IJP.026.0137A

Woods, D. W., Flessner, C. A., Franklin, M. E., Keuthen, N. J., Goodwin, R. D., Stein, D. J., & Walther, M. R. (2006). The Trichotillomania Impact Project (TIP): exploring phenomenology, functional impairment, and treatment utilization*. Journal of Clinical Psychiatry, 67*(12), 1877-1888.

Woods, D. W., Fuqua, R. W., & Outman, R. C. (1999). Evaluating the social acceptability of persons with habit disorders: The effects of topography, frequency, and gender manipulation. *Journal of Psychopathology and Behavioral Assessment, 21*, 1-18. https://doi.org/10.1023/A:1022839609859

Woods, D. W., Fuqua, R. W., Siah, A., Murray, L. K., Welch, M., Blackman, E., & Seif, T. (2001). Understanding habits: A preliminary investigation of nail biting function in children. *Education and Treatment of Children, 24*(2), 199-216.

World Health Organization (2020). *International Classification of Diseases for Mortality and Morbidity Statistics* (11th Revision). Retrieved February 20, 2021, from https://icd.who.int/browse11/l-m/en

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (3rd ed., pp. 257-272). SAGE Publications.

Zarrell, R. (2015, April 29). *This doctor shares her amazing blackhead extractions on Instagram*. Buzzfeed. Retrieved February 20, 2021, from https://www.buzzfeed.com/rachelzarrell/this-instagram-is-the-perfect-cure-for-people-who-love-poppi

Zeigarnik, B. (1938). On finished and unfinished tasks. In W. D. Ellis (Ed.), *A source book of Gestalt psychology* (pp. 300–314). Kegan Paul, Trench, Trubner & Company. https://psycnet.apa.org/doi/10.1037/11496-025

Zhao, Z.-Q., Liu, X.-Y., Jeffry, J., Karunarathne, W. K. A., Li, J.-L., Munanairi, A., Zhou, X.-Y., Li, H., Sun, Y.G., Wan, L., Wu, Z.-Y., Kim, S., Huo, F.-Q., Mo, P., Barry, D. M., Zhang, C. K., Kim, J. Y., Guatam, N., Renner, K. J., Li, Y. Q., & Chen, Z. F. (2014). Descending control of itch transmission by the serotonergic system via 5-HT1A-facilitated GRP-GRPR signaling. *Neuron, 84*(4), 821-834. https://doi.org/10.1016/j.neuron.2014.10.003

Zucchelli, F., Donnelly, O., Williamson, H., & Hooper, N. (2018). Acceptance and Commitment Therapy for people experiencing appearance-related distress associated with a visible difference: A rationale and review of relevant research. *Journal of Cognitive Psychotherapy, 32*(3), 171-183. https://doi.org/10.1891/0889-8391.32.3.171

Appendix 1

Website Copy and Recruitment Materials

Appendix 1.1

Copy from 'Welcome page' [https://skinpickingweb.wordpress.com/]

Welcome

Do you pick your skin?

I am recruiting UK research participants for my Counselling Psychology doctoral thesis and would love to talk to you. You need to be at least 18 years old, based in the UK, and you'd need to consider your skin picking to be problematic and distressing.

I and many other professionals believe that we need to know more about the experience of people who pick their skin. Until now, most skin picking research has described picking by using scales and numbers, which sometimes risks losing sight of what's actually happening and what skin picking means. I think that it's really important for research to allow people to speak about their own personal experiences, using their own words, so I am writing a report that represents the thoughts, feelings, knowledge, opinions and frustrations of real people with real, lived experience of picking. What I write will be guided by what **you** tell me and what **you** feel is important. And because I want people confident about taking part there are several options for how you talk to me – face-to-face, Skype, email and Whatsapp and other instant messenger (IM) tools.

Want to know more about what taking part will involve? Find more information here. [link to *What will it involve?*]

Are you interested? Register to take part. [link to *Take part*]

UWE Bristol
University of the West of England

Appendix 1.2

Copy from 'What will it involve?' [https://skinpickingweb.wordpress.com/about/]

What will it involve?

Stage 1: Information

First things first, read through this page and have a look at our information sheet. It'll give you some idea about what to expect from taking part.

Stage 2: Screening and consent

This is a simple very brief questionnaire (that will take a minute or two to complete) to make sure that you're over 18, UK based and that you pick your skin in a way that you consider problematic. I'll ask for a bit of basic info about you so that I've got some idea about the type of people taking part (e.g. gender, age etc.) – all of this will be kept strictly confidential. I'll also ask you to give consent for me to capture what you say and write about it in my doctoral thesis and at least one academic paper.

Stage 3: Interview

This will depend on how you want to talk to me. I can do face-to-face interviews if you live near me (I'm based in Bristol), or if you don't want to meet face-to-face or live further away we can use Skype (full video call or just the audio), telephone, email or Whatsapp (or another instant messenger tool). If you go for face-to-face or Skype then we'll probably talk for about an hour (but it's good if you can allow for up to two hours, so we don't feel rushed). If you go for email or Whatsapp then the interview may be more gradual over a few days or weeks. I'll audio record spoken interviews and transcribe them, then all the transcripts, emails and/or messages will be anonymised. I'll change or remove anything that could identify you.

Stage 4: Debrief & thank you

Taking part in research like this can be tiring and thought provoking, so I'll encourage you to take some time to look after yourself and give you some ideas about support.

Stage 5: My bit

Once I've spoken to enough people, I'll look at what's been said. I will look for themes in people's stories, and also note any important differences. I'll try to decide what stands out the most and what would really add to what's known about skin picking, and then I'll begin to write it up. I'll include a summary of participants' basic demographics to give an idea of who took park.

I'll write up the research as a thesis (a really long, in-depth report) for my Professional Doctorate in Counselling Psychology and also as an academic paper. I'll work towards getting the paper published so that other professionals, researchers and commissioners can read it and better understand what skin picking means.

Your participation will be completely anonymised so no one will ever need to know that you took part – unless you want to tell them, of course.

That's it!

If you have any questions, get in touch. [link to *Contact us,* Appendix 2.4]

Once you've read through our information sheet [link to *Information sheet*, Appendix 2.3], tell us that you'd like to take part here [link to *Take part,* Appendix 2.5].

Appendix 1.3

Copy from 'Information sheet' [https://skinpickingweb.wordpress.com/information-sheet/]

Information Sheet

Please read this if you'd like to take part.

Thank you so much for your interest in this research. I think that it's so important to hear the voices of people who pick their skin, but it's also really important that you feel safe and comfortable taking part.

I understand that this can be a difficult and upsetting thing to talk about. Please be assured that I am not here to judge – it is my job to listen carefully to you and to try to understand your perspective as fully as possible.

If you would like to stop at any time please just say. You do not need to give a reason. We could take a break and come back later, or you have every right to stop the interview and withdraw completely if you choose. If you decide to withdraw from the research after you've completed your interview, please email me (suzy.eanderson@gmail.com, or send me a message through this site) with your username. Please note that there are certain points beyond which it will be impossible to withdraw from the research, such as once data has been anonymised and mixed in with what other people have said. Therefore I strongly encourage you to contact me within a month of participation if you wish to withdraw your contribution.

So many people pick their skin but we know very little about it. So far most research has been to give people scales and questionnaires, but I think this loses sight of the real, lived experience of skin picking. So, I will be asking you open questions and listening to your response. It's important that you know that there are no right or wrong answers. I am interested in YOUR experience and what YOU think. To make sure I capture your 'voice' I am likely to use anonymous direct quoting from your interview in my report.

If you talk about something that could identify you (such as where you live, your age or profession) then I'll anonymise it. This means that I'll either make sure it's either left out of the report or I'll change it to something vague enough that it isn't possible to tell who you are (for example, if you say that you're a nurse I might change it to 'healthcare professional').

I take your data protection very seriously. The personal information collected in this research project (e.g., online using the Qualtrics survey software, interview recordings, interview transcripts) will be processed by the University (Data Controller) in accordance with the terms and conditions of the

Data Protection legislation. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law. Your personal information will be used/processed as described on this participant information sheet, and will be seen by myself and my supervisor (and potentially also the examiners).

Personal information including interview transcripts will be kept until the research is published, or until final award is conferred (whichever is later). This data will be stored in password protected files and any printed materials or copies will be stored securely in a locked filing cabinet when not in use. You have a number of rights in relation to your personal data. For data protection queries, please write to the Data Protection Officer, UWE Frenchay Campus, Coldharbour Lane, Bristol, BS16 1QY, or dataprotection@uwe.ac.uk

I have a rough list of questions to ask to start the conversation but would like you to feel able to talk freely – it may be helpful to see the interview as more of a conversation. I will have a list of things that I'd like to ask you about, but this is only a very rough guide. I'd really like to hear about what you consider most important about your picking, so it's great if we go off track to include this. If ever you don't understand what I'm asking please just say and I'll try to re-word the question. Some questions will be deliberately vague as I don't want to 'steer' the conversation too much by asking really specific things – you can answer these however you like.

I am sure that we won't be able to cover everything in the interview so if you have any extra points to add later you are very welcome to contact me by email.

At the end of the interview I will give you some information about how to access further support. It's also really important that you prioritise taking some time to wind down and look after yourself as being interviewed like this can be tiring. I'd recommend planning a relaxing activity for once we've finished – a hot bath or a walk to clear your head.

Once I have completed the research I can send you a short summary report or copy of any published papers, should that interest you.

Tell me if you'd like to take part here [link to *Take part*, Appendix 2.5].

UWE Bristol | University of the West of England

Appendix 1.4

Copy from 'Contact us' [https://skinpickingweb.wordpress.com/contact-us/]

Contact us

To contact Suzy Anderson (lead researcher) please use the contact box below.

Email (required) [text box]

Comment (required) [text box]

SUBMIT [submit button]

We are based at the University of the West of England (UWE) in Bristol.

This research has been reviewed and approved by the UWE Health and Applied Sciences Faculty Research Ethics Committee. If you have any concerns about taking part or the manner in which it is being conducted, please contact my main supervisor, Dr Victoria Clarke.

Victoria's email address is Victoria.Clarke@uwe.ac.uk [hyperlink]

Her address:
Victoria Clarke, Associate Professor in Qualitative and Critical Psychology
Department of Health and Social Sciences
University of the West of England
Bristol BS16 1QY

Appendix 1.5

Copy from 'Take part' [https://skinpickingweb.wordpress.com/contact/]

Take part

To register your interest, please leave your details in the contact box below. This will send me an email and I'll get back to you as soon as possible.

Please give yourself a username – this can be whatever you'd like – I'll use it to keep your information together. It will be kept private and won't be published in the report.

Please also give a contact email address so that we can arrange your interview. Again, this will be kept completely private and only used to arrange a time to talk. If you would rather I contact you some other way, such as by telephone, text or WhatsApp please let me know in the 'comment' section and include contact details.

Please double check your email spelling before submitting!

Username(required) [text box]

Email(required) [text box]

Comment [text box]

SUBMIT [submit button]

UWE
Bristol
University
of the
West of
England

Appendix 1.6

Copy from 'Who we are' [https://skinpickingweb.wordpress.com/page/]

Who we are

My name is Suzy Anderson and my main supervisor is Dr Victoria Clarke.

I am a trainee Counselling Psychologist in the Department of Health and Social Sciences at the University of the West of England, Bristol, working towards my final doctoral thesis. I have always been interested in skin picking and a few years back I looked into what was known about it. I realised that the research out there didn't tell me much about how people experienced or made sense of their skin picking. I work as a counsellor and I'm very aware that people who pick can find it distressing and it can cause them all sorts of difficulties. I was surprised that no one seemed to be asking them about their skin picking and how they felt about it. So, that's what I'm doing. I will write up the research for my doctoral thesis.

Victoria is my supervisor. She is an Associate Professor in the Department of Health and Social Sciences at the University of the West of England, Bristol. She's well known in the world of research for her papers and text books on qualitative research and especially 'Thematic Analysis' – a way of analysing interviews and other types of qualitative data. I'm going to be using this approach so it's great to have Victoria contributing her experience and expertise. You can read more about Victoria here.

In 2017 we published a study that looked at how people talked about their skin picking in online forums. We found that people who picked their skin often had a really tough emotional experience and it impacted on their lives in many ways. It was all really helpful to know but I found myself wanting to ask more questions and better understand people's experiences, so I decided to do a larger piece of research using interviews. We hope that the more we understand what goes on for people the better we can support them. This research will contribute to my doctoral thesis and one or more academic papers.

UWE Bristol | University of the West of England

Appendix 1.7

Copy from 'Thank you' [debrief page, https://skinpickingweb.wordpress.com/thank-you/]

Thank you!

I have written the following on the basis of my experience as a trainee Counselling Psychologist and five years of clinical experience as a counsellor. This is not intended as a substitute for professional treatment or advice. Please seek support from a professional should you have any questions or require help managing your picking or your emotional experience.

Thank you so much for contributing your thoughts and experience to this research.

PLEASE take some time to **look after yourself**. If you have a place in the house where you do most of your picking – try not to go there for an hour. If you spend hours in front of the mirror – try not to look in one for an hour. Instead, do something that relaxes you. Here are some ideas:

- have a hot bath in the dark with candles
- listen to your favourite music with your eyes closed
- go for a walk and find a good view
- make a nest on the sofa and watch your favourite feel-good film
- The magazine Psychology Today have some good ideas for simple self-care activities here [link to https://www.psychologytoday.com/gb/blog/shyness-is-nice/201403/seven-types-self-care-activities-coping-stress]

Online resources

The internet is great for knowing that you are not alone. There are so many people out there who pick, and many of them talk about it online. Some of them may have advice which you find useful. Perhaps simply reading other people's stories may help you feel more accepting of your picking, which is really helpful if you pick when you're upset. Look after yourself though and be wary anyone asking you to pay for advice.

Ideas that might help

There are lots of ideas out there. As with most things, people who pick their skin are all individuals so what works for one may not work for another, so it may be worth trying a few different things.

Habit reversal therapy: this involves noticing when you pick and choosing a 'competing' action – useful for people who pick without noticing. There is some information online about it, or your GP may be able to refer you. There's some great information from the NHS here on the Skin Support website, which is written from a dermatological perspective.

Help for underlying skin issues: some people pick at dry or bumpy skin. If this is true for you, it could be worth seeing your GP if you haven't already. They may be able to help you care for your skin with topical treatments or emollients.

Accessing counselling: some people notice they pick if they're upset or angry. Counselling may help you to develop alternative ways of responding to your emotions. Many organisations offer low cost counselling, or you can access therapy on the NHS. NHS therapy is done through a system called 'IAPT' (Improving Access to Psychological Therapies). If you Google 'IAPT' and your location you should be able to find details of how to refer yourself. Alternatively see your GP and they can refer you.

Building your support: many people hide their picking, even from those closest to them. If you can build the courage to talk to family or friends then you'll have more people looking out for you and supporting you. It's also a great relief to know that you don't have to hide.

Knowing how you pick: would you pick less if you had a dimmer bathroom light? A mirror that didn't magnify? Shorter finger nails? More to do in the evening? Small changes might reduce your picking.

Knowing your triggers: does going somewhere, seeing someone or doing something tend to lead to you picking? If you can spot it coming you can plan an alternative activity that may help to distract you from picking – perhaps something that keeps your hands busy, or a relaxing activity that gives you time to unwind.

Self-compassion: this is incredibly important. My last research project into skin picking showed that people were very distressed, and some of them were incredibly hard on themselves. And it's REALLY hard to think straight or change what you're doing when someone's shouting at you, even if you're doing the shouting at yourself. Imagine a child struggling with maths – is it most helpful to shout at them, or be patient and encouraging? It's the same when we're adults 'encouraging' ourselves. Self-compassion and patience take practice though – developing a kinder inner voice doesn't come naturally to a lot of us. A good start is to arrange more self-care activities (see the list at the top of this page), and try to talk to yourself more gently, like you would to a close friend. If you really struggle, you might find it useful to talk this through with someone close to you or a counsellor.

Please be aware that many people find that their GP or counsellor doesn't know a lot about skin picking, as it's not often talked about. This shouldn't stop them being able to help though. It might help if you show them this debriefing sheet so that they have an idea about where to start.

Appendix 2

Consent and Screening Questions

Skin Picking Research

Thank you for your interest in participating in this research. This form is to collect some basic information about who you are and to check that you fully consent to taking part.

Please confirm your username. It will be used to keep your information together until your interview has been transcribed. It will be kept private and won't be published in the report.

What is your age? Participants must be over the age of 18 years.

What do you consider your gender to be?

Are you based in the United Kingdom?

Do you pick your skin in a way that you consider problematic?

Yes / No

Does it cause you some distress that you pick your skin?

Yes / No

Please confirm how you would like your interview to take place. You can pick whichever of the following that you feel most comfortable with.

Face-to-face
Skype (video)
Skype (audio only)
Telephone
Email
WhatsApp
Facebook Messenger
Text

Do you have any concerns or worries about taking part, or any questions that you'd like answered?

A reminder of your rights as a voluntary participant

- This research is interested in my unique perspective and my words are likely to be quoted directly
- Any quotations will be entirely anonymous (a fake name chosen by the researcher will be used)
- Any identifying information that I give (such as location, age, profession) will be removed or replaced with suitably generic or vague alternatives
- This research is being conducted to contribute to an academic counselling psychology professional doctorate thesis with the intention of publishing one or more academic paper
- I am taking part in this research voluntarily
- I am able to stop the interview at any point, either to pause or to stop completely.
- I am able to withdraw from the research at any point up until interview analysis and do not need to give a reason for doing so
- What I say will be transcribed and analysed by Suzy Anderson (lead researcher)
- The personal information collected in this research project (e.g., online using the Qualtrics survey software, interview recordings and interview transcripts) will be processed by the University in accordance with the terms and conditions of the 1998 Data Protection Act
- My personal information will be processed as described on the participant information sheet
- Any personal data will only be seen by Suzy Anderson and Victoria Clark (main supervisor) and potentially the examiners unless permitted or required by law to do so
- I understand that the demographic data for all of the participants will be compiled into a table and reported in Suzy Anderson's thesis and in any publications or presentations arising from the research
- This research is for Suzy Anderson's doctoral thesis and that interview recordings and transcripts will be kept until the final award has been conferred or until the research has been accepted for publication, whichever is last
- I am able to contact Suzy Anderson or Victoria Clarke at any point throughout this project should I have any concerns

Consent

Please read and agree to the following statements:
- I have read and understand the information sheet at https://skinpickingweb.wordpress.com/information-sheet/
- I consent to take part in an interview with Suzy Anderson about my experience of skin picking for the purposes of her doctoral research; I understand this interview will be recorded and anonymised extracts from the interview may be quoted in her thesis and in other presentations and publications arising from the research

☐ Yes I consent

☐ No I do not consent

Date of consent

Appendix 3

Interview Structure

Appendix 3.1

Blurb used to introduce interviews (either read or pasted depending on the interview modality)

Thank you for completing the screening and consent questions. We are now ready to begin your interview. The interview has six sections: ‘features of skin picking’, ‘experience of skin picking’, ‘coping’, ‘sense making’, ‘talking about picking’ and ‘close’. I will let you know when we move onto a new section so that you have some idea of where we are, but we may move around a bit between sections if that’s where the conversation leads us.

And just a reminder that you can stop or take a break at any time – the interview can be done entirely at your pace. If you want to stop and don’t want to carry on, I will use what you’ve already said unless you tell me otherwise. And if you don’t feel comfortable answering anything please do just say. Also, please don’t worry about typos or grammar – I’d much rather you felt able to talk freely about whatever comes into your head.

Is there anything you’d like to ask before we get going?

Appendix 3.2

Interview schedule covering main areas of interest, intended to be used flexibly

Features of skin picking

- To start with, I’d really like to know a bit about how you pick. Please could you describe to me how you typically pick your skin?
- Where on your body do you pick? Do you pick anywhere else on your body?
- What is it that you pick at, if anything? Do you have any diagnosed or undiagnosed skin conditions that impact your picking?
- How often do you pick?
- When do you tend to pick?
- How much or how long do you pick for?
- Does the picking hurt or damage your skin?
- Do you notice that you pick in different ways? What do you think changes/influences the different ways that you pick?
- Where are you when you pick (home, work etc)?
- When did you start picking more than you’d like to?
- Has your picking changed over time?

Experience of skin picking

- How do you feel before/during/after picking?
- How do you feel about the fact that it happens?
- What do you feel about your skin in general?
- What kind of relationship do you feel that you have with your body? Does your skin impact how you see your body?
- How do you feel about any damage that you cause to your skin?
- What is it that you find distressing about picking?
- What difference would it make if you didn’t pick your skin?

Coping with picking and distress

- Do you do anything to manage your picking? Are there things that you’ve tried in the past?
- What helps you reduce/stop picking?
- Do you do anything to manage any skin damage?
- Do you do anything to help reduce the distress that you have relating to your picking?

Sense making

- Why do you think you pick?
- When is your picking particularly good/bad? Have you noticed any patterns?
- Do you do anything else that you consider similar to picking? In what ways are they similar?
- Have you come across the idea of skin picking as a disorder? How do you feel about it being described like this? Does it change the way that you see your picking?

Talking about picking

- Do you talk to other people about your picking?
- How is it to talk to me about it now?
- Why did you choose to be interviewed by (email, skype, whatsapp)?
- Do you think your answers would be different if I were interviewing you in a different way?
- Do you know anyone else who picks their skin? What do you think about their picking?
- Have you ever sought support?
    - YES – how was your experience? Was it helpful? What would you change?
    - NO – what stops you? What would be useful/unhelpful if you were to get support?

Close: Is there anything you’d like to say that we haven’t talked about?

Appendix 4: *Risk Assessment*

University of the West of England
BRISTOL

GENERAL RISK ASSESSMENT FORM

Ref:

Describe the activity being assessed: Research using face-to-face or virtual interviews to explore the experiences of individuals who problematically pick their skin. The face to face interviews will take place off campus	**Assessed by (name of student): Victoria Clarke (Suzy Anderson)**	**Endorsed by (name of programme manager or designate): Zoe Thomas**
Who might be harmed: The researcher, participants **How many exposed to risk:** 20 participants, 1 researcher	**Date of Assessment: 02/02/18**	**Review date(s): 02/02/2019**

Hazards Identified *(state the potential harm)*	**Existing Control Measures**	**S**	**L**	**Risk Level**	**Additional Control Measures**	**S**	**L**	**Risk Level**	**By whom and by when**	**Date completed**
The potential for researcher distress reading and analysing accounts of skin picking	This will be carefully monitored through use of supervision, peer support and use of personal therapy throughout the research.	1	3	3						
The potential for participant distress when participating in interviews and describing distressing experiences. Some participants may have received a diagnosis relating to their mental health and all will have reported distress as a result of their picking (as per inclusion criteria), and as such will be considered to be vulnerable adults.	The researcher has a recent enhanced DBS check (August 2017). Distress will be closely monitored throughout interviews. The researcher is a trainee Counselling Psychologist with five years clinical experience and will draw on this and work with appropriate sensitivity. A comprehensive participant debrief sheet has been developed drawing on research-based good practice. Participants will understand that they may pause or stop the interview at any point or withdraw from the research without consequence. The research methodology has been deliberately constructed so as to give participants power over the extent to which they reveal themselves to the researcher and the pace at which they engage (e.g. offering synchronous and non-synchronous methods). All participants are over the age of 18 and will be aware that they will be asked questions about their skin picking.	2	2	4						
Risk to researcher when meeting unknown participants	Meeting in neutral locations with safe access. The researcher will make the details of the meeting available to either a personal contact or	2	2	4						

	supervisor and will ‘check-out’ at the end of the session. Thus the researcher will use the standard safety buddy protocol when conducting interviews off site and lone working									

RISK MATRIX: (To generate the risk level).

Very likely 5	**5**	**10**	**15**	**20**	**25**
Likely 4	**4**	**8**	**12**	**16**	**20**
Possible 3	**3**	**6**	**9**	**12**	**15**
Unlikely 2	**2**	**4**	**6**	**8**	**10**
Extremely unlikely 1	**1**	**2**	**3**	**4**	**5**
Likelihood (L) ↑ Severity (S) →	**Minor injury – No first aid treatment required 1**	**Minor injury – Requires First Aid Treatment 2**	**Injury - requires GP treatment or Hospital attendance 3**	**Major Injury 4**	**Fatality 5**

ACTION LEVEL: (To identify what action needs to be taken).

POINTS:	**RISK LEVEL:**	**ACTION:**
1 – 2	NEGLIGIBLE	No further action is necessary.
3 – 5	TOLERABLE	Where possible, reduce the risk further
6 - 12	MODERATE	Additional control measures are required
15 – 16	HIGH	Immediate action is necessary
20 - 25	INTOLERABLE	Stop the activity/ do not start the activity

Appendix 5
Ethical Permission

UWE Bristol University of the West of England

Faculty of Health & Applied Sciences
Glenside Campus
Blackberry Hill
Stapleton
Bristol BS16 1DD

Tel: 0117 328 1170

UWE REC REF No: HAS.18.02.099

5 June 2018

Address redacted

Dear Susan

Application title: The role of self-conscious emotions in problematic skin picking

I am writing to confirm that the Faculty Research Ethics Committee are satisfied that you have addressed all the conditions relating to our previous letter sent on 13th April 2018 and the study has been given ethical approval to proceed.

Please note that any information sheets and consent forms should have the UWE logo. Further guidance is available on the web: http://www2.uwe.ac.uk/services/Marketing/about-us/doc/one-page-portrait-UWE-word-doc-with-colour-logo.docx

The following standard conditions also apply to all research given ethical approval by a UWE Research Ethics Committee:

1. You must notify the relevant UWE Research Ethics Committee in advance if you wish to make significant amendments to the original application: these include any changes to the study protocol which have an ethical dimension. Please note that any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee. http://www1.uwe.ac.uk/research/researchethics/applyingforapproval.aspx

2. You must notify the University Research Ethics Committee if you terminate your research before completion;

3. You must notify the University Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.

Please note: The UREC is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the UREC and its committees.

We wish you well with your research.

Yours sincerely

Signature redacted

Dr Julie Woodley
Chair
Faculty Research Ethics Committee

c.c. Victoria Clarke

Appendix 6

Examples of Coding Process

[Redacted for participant privacy, available for examiner assessment as a separate appendix file]

Appendix 7

Two Examples of Categorisation of Participants' Quotes in 'Analysis directory'

Example 1: Self-control

[some of the quotes below were used to illustrate 'loss of control' cognitions in the context of theme '*Shame of Picking'*]

Distress at lack of self-control
"Afterwards I often feel bad about the damage I've done, and this can be anything from anger at myself for lack of control especially if I've been trying really hard to keep my skin nice, but it's usually just sadness and I'm often a bit teary and feel guilty." – Annie
"you think you're in control and then you're not. And I feel really bad about not having that self-control… it's a difficult position because sometimes I pick too much and I'm like "ah I have no control over this"… but I know inside yes I can, it's my body, it's my brain. I could stop anytime but something, something doesn't. And this part, this part that I don't seem to have control over, that's what's troubling me" – Olivia
"The fact that I'm doing something that is harming myself and I'm unable to stop it at the moment is distressing. Also the fact I have got to the point where I'm doing something like this instead of being "normal" like other people." – Jenny
"And yeah there's a kind of a loss of control feeling with [the feeling that you can't stop picking] as well. Because you realise that you don't have the control that you now want… it can make you feel quite angry with yourself." – Lisa

Self-consciousness about doing it to self
"I very self conscious, I think it's the embarrassment of them finding out what causes them, what I do and them not understanding it. Think people think you can just "stop" picking and it's not as simple as that… [I'm embarrassed] because I'm ashamed of my body but it's me that's doing it to myself, I can't blame it on anything or anyone apart from me." – Melanie
(when talking about how his shame in picking damage being noticed relates to being seen to have weak self-control) "I almost feel I should be able to do better." – Jeff

Self-consciousness about appearing out of control
(when asked what she'd worry about if she talked to other people about picking) "That I don't have self-control. And that I'm disgusting. Umm, err. But yeah it's just disgusting basically. Why, they would think, 'why are you doing that disgusting thing'" – Lisa

Damage would be ok if an accident – implies that shame relating to picking damage has something to do with the act of picking/self-inflicted context
"I just say I cut it on something. Rubbish excuse, I more brush it off and change the subject." – Rebecca
"It's not something that has happened to me by accident that was out of my control, I wouldn't be ashamed then, so it's got to be that it's something I've physically done to myself and I'm ashamed that I haven't been in control of myself enough to not do it." – Leanne
"I will often cover them up with plasters to allow them to heal and if anyone asks I just say I've cut myself" – Jeff

Example 2: I am misunderstood

[some of the quotes below were used to illustrate participants feelings of being misunderstood by others, including professionals, and how this misunderstanding was silencing, discussed in the context of theme '*I am misunderstood'*]

Picking is misunderstood
"I guess aside from my boyfriend nobody else really understands what it's like from my perspective, my parents always tell me to 'just stop picking' and some friends will give me skincare tips or tell me to eat healthier 'to get rid of acne', so it's annoying feeling misunderstood because people just don't understand it I find" – Eden
"I think [I worry] because people would assume I have acne but I know that's not true so I don't like being put in that box when it's more of a mental condition than a skin condition and people don't understand that" – Eden
"People judge because they think it's self harm, or always ask what's happened. It's just awkward." - Rebecca
"I feel that people who comment could be more thoughtful and less judgmental. I feel a lack of understanding leads to these comments… if they were more understanding and saying things like "it must be hard to not pick" or "have you been stressed or anxious" "I see you've been picking, do you need to talk or share anything" whether that would change how I feel I'm not sure but it would certainly help." – Jeff
"Nobody has ever really asked open like, no one has ever asked me with an open question what it is. They've always concluded, they haven't even asked me the question. I've had people talk to me about acne treatments and stuff, and I think it's just one of these things that's not really well understood or well known." – Lisa
"But I do feel that people literally do not understand because it's not part of their psychology. And I can put myself in their shoes and see that if it's not part of you then how would you recognise it? There's no way to – unless they're like, making like an effort to be extremely and exceptionally empathetic… Almost like you're starting to talk another language to them, you're going off their map of understanding" – Lisa
"Ive had lots of people shout at me, tell me its bad, its self harm… My grandma would say that the most, she thought i was just digging at it for the sake of it. It felt like she was lying about me to everyone." – Sam
"…biting your nails is supposedly a thing you grow out of, and for adults to ask what happened and you try to say that you picked at your fingers they quite often just ask why. I know they aren't trying to be rude but I feel like even if I tried to explain it wasnt something I controlled they wouldn't understand that that is true" - Sky

People think it's easy to stop/Just stop picking ('just stop' is shaming)
"I think [my partner] found it hard to understand that it's not as easy to stop… like "what just stop doing that"... I just sort of I say to him "you know it's not as easy as that", you know, "it's a compulsion I can't just stop"." – Aisha
"typically the thing I would hear and what annoys me the most and previous boyfriends – probably people trying to help but it's not helping, things like "stop scratching, stop scratching, stop scratching" like "don't do it, no", that are not helpful at all… [that makes me feel] very misunderstood. Like, if it was that easy to stop I would do it!" – Olivia
"[I haven't been] directly shamed no, but I'm told all the time to just stop picking how hard can it be and it's hard cause they don't understand how much I could just stop picking but I can't" – Melanie

"I guess when people mention it I'm made to feel that I shouldn't do it. There seems to be a lack of understanding. Like it's something I should be able to control and is easy for me to stop doing." – Jeff

Disinterested/dismissive professions
"Been doctors (less than interested)… I think I was told just to 'stop it'" – Ellen
"I'd actually been to my GP at age 18 with a print out of a dermatillomania internet page and said very nervously I think I have this, and the young GP did a sort of eyebrows up face and said "Is this self diagnosed?!" Like he didn't have time for crazies today! I'll never forget how I felt it was awful. That stopped me from going back to any professional for 10years." – Annie
"The nurses who dressed the wounds referred me back to gp, I guess as long as in not slicing my wrists theyre happy" – Marcus
"Indeed, I dont think they have taken it seriously and that leaves me feeling that I am just being silly and over concerned... which ironically makes me wanna pick lol" – Marcus
"Well in my experience [health professionals] seem to dismiss out of hand my picking, barely even acknowledge it" – Marcus
"with my doctor I said to her about it in passing and she was just like "well I can write it down on your notes but it doesn't really mean anything" and I was like "ok then love"." – Aisha
"…there needs to be more to help with it though, I've stopped asking doctors cause all I get is more antidepressants… I'm not really sure I know [what would help] to be honest I just know that I don't pick all the time cause I'm depressed" – Melanie
"I've spoken to various GPs about some of my picking before, but they've without exception dismissed it as unimportant." – Julie
"I saw a psychiatrist and when I mentioned it to him and showed my legs to him he pretty just ignored what I said and started talking about something else! … it was annoying because to me it is a problem, yet he just made it seem like it was just nothing… I'd just like them to take it seriously, rather than making me feel like I'm just being silly and it's not a problem at all" – Jenny
"Ive only had experience with a few [professionals] but i had a long term [therapist] who didn't listen to anything i wanted to talk about and focussed on one specific trauma the whole time. Regardless of conversation topic" – Sam
"…there seem to still be many professionals who aren't interested or don't want to take the time to try and understand it." – Leanne, WhatsApp

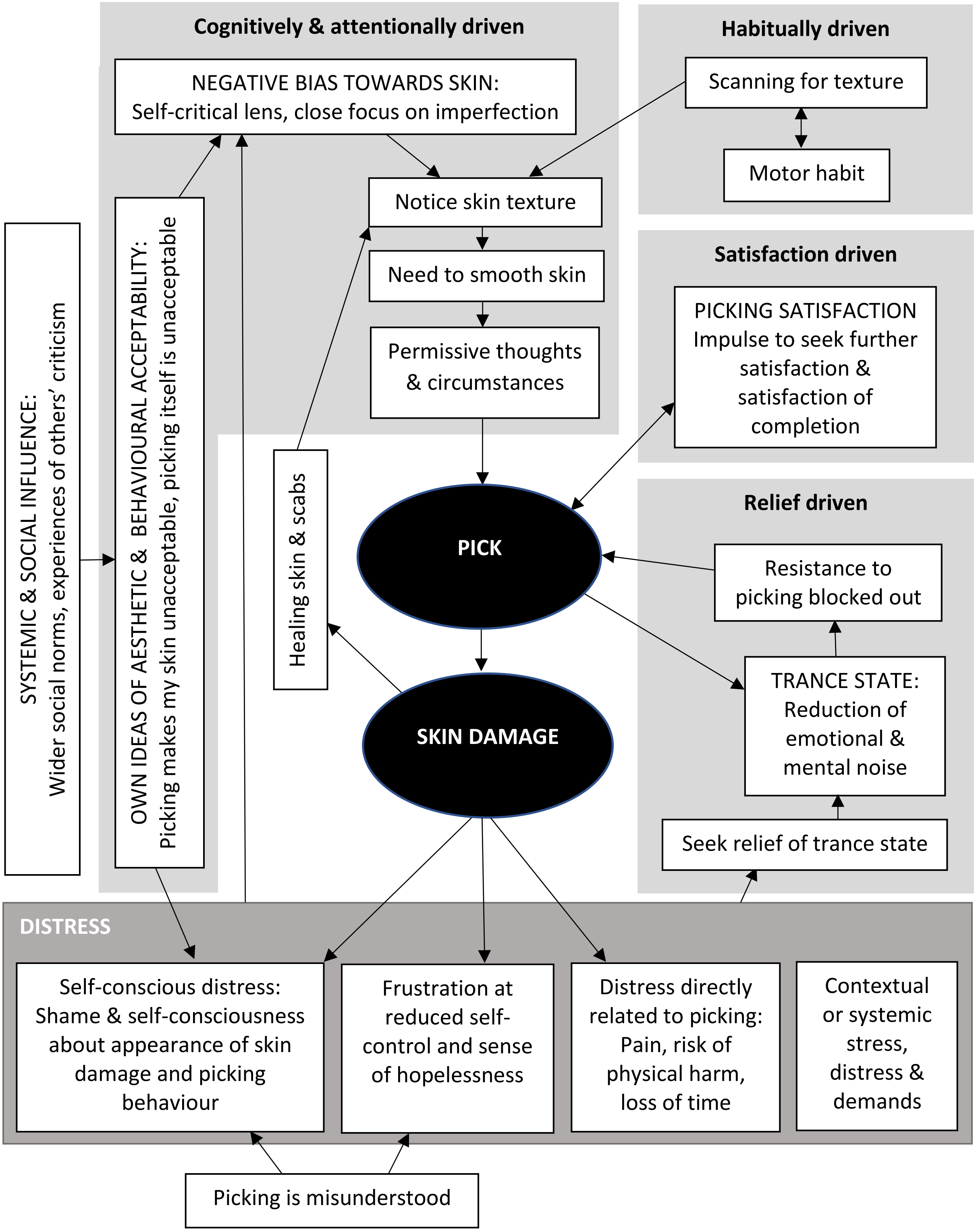
Being misunderstood is silencing
"I just think I wouldn't wanna talk about it because nobody understands it, like I said earlier most people say 'have you tried just not picking your skin' or they assume it's just acne. And then talking in detail about it I just find embarrassing because a lot of people probably think it's quite gross really." – Eden
"[I don't talk about picking because] It's awkward. They wouldn't understand, and they don't need to know." – Rebecca
"it's mainly seen as a bad habit "oh yeah everyone does it but it's just a bad habit". But I think it's more than that. And the fact that people overlook this thing, and just treat it as very benign is a bit annoying, and you're not very eager to share your experience with people like that." – Olivia
"I'm more careful about talking about it now, I do keep it more to myself because I do feel like people don't really understand." – Lisa
"I think feeling like he wont understand [stops me from talking to my partner]" – Sky
"There's only one person I think I could talk to openly and not be judged or patronised, but she's got enough on her plate of her own, it's just never come up or been the right time to bring it up with her.

Not that I think it would make any difference anyway so it's not something that I'm looking to do any time soon." – Leanne

It's hard work to explain picking to people
"It's just more hassle then it's worth getting into conversations about it lol" – Rebecca
"for me it starts to feel a bit like banging your head against a wall. And it's almost like it takes more energy to do that than what you get from it. Like, you know, not a very good investment [laughs] Like flogging a dead horse." – Lisa

Appendix 8

The relationships between skin picking experiences: Rough formulation of problematic picking drives, cycles and consequence based on participant sense-making, intended to assist in the process of noticing connections between experiences and organising the thesis analysis.



Appendix 9

Summary of Thesis

The Problem with Picking: Permittance, Escape and Shame in Problematic Skin Picking

Word count: 5999

Abstract:

Objectives: Problematic skin picking is a poorly understood experience characterised by a drive to pick the skin and related psychosocial impact. This thesis summary presents a rare qualitative perspective on the lived experience of problematic skin picking, prioritising participants' voices and sense-making.

Design: An in-depth qualitative study of individuals who self-identified as picking their skin problematically and experienced related distress.

Methods: Seventeen UK based participants were recruited online and interviewed about their skin picking. Participants were given choice of interview modality, including instant messenger platforms, telephone, email and *Skype,* to maximise comfort and improve the accessibility of the study. Transcripts were analysed using thematic analysis.

Results: Three themes offering novel insight into the phenomenology of participants' picking are highlighted and explored: (1) how cognitions and circumstances drove and permitted picking, (2) how participants 'zoned out' while picking and the escape or relief that this attentional experience offered, and (3) participants' distress in how they felt their picking may appear to others.

Conclusions: This study contributes depth and novel ideas to the understanding of picking phenomenology and identifies how environmental factors, cognitions, contextual distress and shame may be considerations in therapeutic intervention. It presents the complexity of picking sense-making and demonstrates the need for individual formulation.

Conclusions for practice:

- Problematic skin picking is a heterogeneous and complex experience. Intervention needs to respond to individual presentations and be centred around individuals' definitions of what is problematic.
- The drive to pick and to continue picking is impacted by how easily it might be accommodated within daily life, suggesting environmental, systemic and cognitive factors that may give opportunity for intervention.
- Picking's use in emotional regulation and coping may be explained by the escape offered by its attentional experience. Therapy may benefit from considering contextual emotion and nurturing alternative coping strategies.
- Shame defines the experience of skin picking regret for many. This distress may be a useful target for therapy and has significant implications for the therapeutic relationship.
- It may be helpful for practitioners to have a pre-existing understanding of skin picking to guide exploration and to help to normalise the experience.

Background

Picking at skin is a common behaviour, typically giving little cause for concern, that may relate to social bonding, tension reduction, and skin hygiene and appearance (Bohne et al., 2002; Dunbar, 2010; Keuthen et al., 2000; Troisi, 2002). For some, picking may be damaging and problematic, and may be accompanied by distress and dysfunction (e.g. Arnold et al., 1998). The conceptualisation of this more problematic skin picking (SP) has been subject to increased research attention over the past two decades. Research has been almost exclusively quantitative with little representation of subjective, lived experience.

As picking behaviour is not intrinsically troublesome, SP tends to be differentiated from benign picking using criteria more defining of ‘problematic’ than of ‘picking’. In 2013 SP was classified as ‘excoriation disorder’ in the Diagnostic and Statistical Manual (DSM-5; American Psychiatric Association [APA], 2013), specifying recurrent picking resulting in lesions, repeated attempts to stop or reduce picking, and that picking causes ‘clinically significant’ distress or functional impairment (APA, 2013). ICD-11 criteria broadly echo these points (World Health Organisation, 2020).

Picking behaviour attracts various conceptualisations and categorisations, including as a ‘displacement behaviour’ (alongside face touching and scratching; Mohiyeddini & Semple, 2013), or a ‘motor stereotypy’ (in autism and intellectual disability research; Singer, 2009; Sukhodolsky et al., 2008). Within the study of SP as a psychopathology, SP has been grouped with other presentations deemed similar. This includes groupings as a ‘body focussed repetitive behaviour’ (BFRB; e.g. Teng et al., 2002), a categorisation describing problematic repetitive behaviours removing small parts of the body (Snorrason et al., 2012), as an ‘Obsessive-Compulsive Related Disorder’ in DSM-5 (APA, 2013) based on features of obsession, compulsion and preoccupation (Abramovitch et al., 2015), and as an issue of impulse control or behavioural addiction (APA, 2000; Odlaug & Grant, 2010). Varied perspectives on categorisation may reflect diversity in SP presentations; SP is widely acknowledged to be a heterogenous in terms of nature, drive and function (e.g. Arnold et al., 2001, Odlaug & Grant, 2010; Siev et al., 2012; Walther et al., 2009).

The Experience of Problematic Skin Picking

Research shows that SP occurs across multiple bodily sites, with the face, hands, arms, scalp, legs commonly targeted (e.g. Prochwicz et al., 2016; Tucker et al., 2011). Picking may occur within daily grooming routines (e.g. Bohne et al., 2002; Deckersbach et al., 2003) or throughout the day (Arnold et al., 1998). SP may be triggered by perceptual and/or tactile dermatological stimuli (e.g. Neziroglu et al., 2008), though it is not well predicted by the condition of skin alone (Gupta et al., 1996;

Prochwicz et al., 2016), and many pick at healthy skin (e.g. Tucker at al., 2011). SP is often intended to improve the skin's texture or appearance (e.g. Arnold et al., 1998).

Researchers have identified variation in attention and awareness while picking (e.g. Arnold et al., 1998). Walther et al. (2009) suggested 'focussed' (picking with awareness), 'automatic' (picking without awareness) and 'mixed' subtypes of SP to describe these differences. In Anderson and Clarke's (2019) qualitative research, automatic picking seems evident in "wandering" (p. 1777) hands unconsciously scanning the skin. Contrastingly, in Deckersbach et al.'s (2003) case report of more focussed SP, the individual described consciously "zooming in on these spots" (p. 255) using a mirror. Picking may begin outside of awareness but become conscious over time (Odlaug & Grant, 2007), and awareness may fade as picking induces a trance-like state (Wilhelm et al., 1999). Capriotti et al.'s (2015) case series included descriptions of drifting "in and out of awareness" (p. 237), and a participant of Deckersbach et al.'s (2002) case reports connected feeling 'mesmerized' to regulation of feelings such as sadness, loneliness and anxiety.

Stress appears to increase body-focussed movements including scratching and self-grooming (Troisi, 2002). These movements are theorised to reduce uncertainty (Perrykkad & Hohwy, 2020) and regulate stress (Mohiyeddini & Semple, 2013). Similarly, episodes of SP are reported to be preceded by emotional discomfort, such as stress, tension and feelings of emptiness (e.g. Arnold et al., 1998; Keuthen et al., 2010; Neziroglu et al., 2008). Elevated stress relates to more time spent engaging in BFRBs, higher psychosocial impact and a worse quality of life (Grant et al., 2015), and SP has been associated with trauma (Machado et al., 2018, Özten et al., 2015). Picking may be followed by relief and satisfaction (Snorrason et al., 2010; Tucker et al., 2011) and reduced tension (Bohne et al., 2002), a dynamic that has led to theories that SP may regulate or alleviate unpleasant emotions (Roberts et al., 2013; Wilhelm et al., 1999). A participant in Deckersbach et al.'s (2002) case reports described picking to relax and not knowing "how to relieve stress in any other way" (p. 272).

Environmental factors may increase picking; boredom and impatience appear to trigger BFRBs (Roberts et al., 2015), 'daydreaming' is associated with picking (Prochwicz et al., 2016), and some mild pickers described picking "to give themselves something to do" (Keuthen et al., 2000, p. 213). Bohne et al. (2002) found picking often occurred when alone at home, though it is unclear whether this might relate to reduced stimulation or a preference for privacy.

The Impact of Skin Picking

By clinical definition SP has problematic consequences spanning physical, psychological and social domains (APA, 2013). Physical damage may include scarring, bleeding and infection (Tucker et al., 2011; Wilhelm et al., 1999), sometimes requiring antibiotic treatment (Odlaug and Grant, 2008) or surgery (Arnold et al., 1998). Pleasure from picking appears fleeting and is followed by increased reports of shame, guilt, hopelessness, depression, anxiety and humiliation (Flessner & Woods, 2006; Keuthen et al., 2000; Simeon et al., 1997; Snorrason et al., 2010). SP is often characterised by psychosocial withdrawal, such as staying home or avoiding events (Anderson & Clarke, 2019; Keuthen et al, 2001; Tucker et al., 2011), and makeup and/or clothing are often used to disguise skin damage (Arnold et al., 1998; Wilhelm et al., 1999).

Treatment seeking for SP is low (Neziroglu et al., 2008; Tucker et al., 2011) and SP is considered under-recognised by medical and psychological professionals (Tucker et al., 2011). Shame and embarrassment may impede recognition and treatment (Bohne et al., 2005). Gallinat et al. (2019) found help seeking to also be inhibited by feelings that picking was not severe enough, uncertainty about who might help, and concerns that professionals would not know about SP.

Considering this impact alongside the affective dynamic of picking, distress appears to be both a consequence and precipitator of picking. Grant et al. (2016) suggest three explanations for the relationship: that picking may cause psychosocial dysfunction that in turn contributes to distress, that the isolation inherent in psychosocial dysfunction might increase picking, or that distress might increase SP that in turn causes psychosocial dysfunction. Anderson and Clarke's (2019) qualitative study supports these explanations and suggests that multiple explanations might be relevant, creating a cycle of picking, distress and psychosocial dysfunction.

The Current Study

Attempts to understand the experience of SP have offered preliminary insight into complex experiences such as consciousness, attention and shame. This research employs a qualitative approach to develop a fuller picture of the subjective experience of SP through participants' own language.

Method

Participants

This research captures the experienced of seventeen participants who self-defined as being distressed by their problematic SP. Use of self-definition reflects concerns about the validity of diagnosis (Cosgrove & Krimsky, 2012; Pearce, 2014), the hope to avoid priming or exclusion based on diagnostic assumptions, and to reflect the ethos of valuing subjective meaning. Subjective definition may also be representative of those self-referring for psychological therapy.

Sixteen participants contributed a complete interview and two did not finish their interviews. One of those with an incomplete interview consented to the inclusion of their responses and has been included. This number of interviews was considered appropriate to 'tell a rich story' (Braun & Clarke, 2013) and represented a range of picking styles, such as 'automatic' and 'focussed'

(Walther et al., 2009). Male participants were purposively recruited as researchers have suggested a gendered difference in the experience of SP (e.g. Prochwicz et al., 2016), though ultimately only two males participated, perhaps reflecting apparent female predominance in SP (e.g. Wilhelm et al., 1999). Participants were aged between 21 and 53 years (mean: 34 years).

Interviews

Semi-structured interviews were chosen to offer a balance of structure and flexibility, providing space for unanticipated issues (Fylan, 2005), and accommodating variation in SP presentations, while addressing the main areas of interest with all participants. Pre-prepared questions covered the features and experience of SP, coping, sense-making and help seeking.

As shame appears central in the experience of SP for many (Anderson & Clarke, 2019) and is inherently relational (DeYoung, 2015), it seemed critical to consider how the interpersonal nature of the interview might impact upon participants' comfort and disclosure. As individuals manage shame in a variety of ways (e.g. perfectionism, withdrawal, exposure; Kaufman, 1996), multiple interview modalities with varying degrees of anonymity were offered. Previous research suggests that use of mixed modalities of interview may benefit recruitment and data quality (Heath et al., 2018) and be useful in exploring the experiences of hard-to reach populations (e.g. Dures et al., 2011). Dures et al.'s (2011) used multiple modalities in their study of the psychosocial impact of Epidermolysis Bullosa, a rare skin disorder. The authors included discussion of the stigma associated with visible difference and noted that participants' visibility to the researcher may impact what was said (Dures et al., 2011), which may be relevant to SP research.

Modalities offered were face-to-face (where practical), *Skype* (video call or audio only), telephone, email and instant messenger [IM]. Face-to-face and *Skype* interviews are considered to benefit from visual cues and communication (Braun & Clarke, 2013; Hanna & Mwale, 2017), whereas email and IM interviews offered greater sense of felt anonymity and participants were not subject to visual scrutiny by the researcher (Braun et al., 2020), and may be useful where participants find face-to-face interviews difficult (Deaken & Wakefield, 2014). Different modalities offered varying degrees of synchronicity; asynchronous methods may be preferred by those wanting to moderate their disclosure (Gibson, 2017). Most participants opted for IM interviews using either *WhatsApp* or *Facebook Messenger* (N=12), 2 for email, 2 for telephone; only one participant requested a face-to-face interview, but as face-to-face was not practical they were interviewed via *Skype* video call.

Data Collection

A website housed recruitment material to allow participants to access information anonymously and without obligation. The website was promoted on two international SP support groups on *Facebook,* and later on *Twitter,* requesting UK-based participants. *Qualtrics* online survey platform (https://www.qualtrics.com) was used for participant screening, consent and recording interview modality preference. Interview lengths varied from 90 minutes for the shortest telephone interview to three months for the longest asynchronous IM interview.

Data Analysis

Reflexive thematic analysis [TA] was used to identify patterns of experience and themes from participants' standpoint (Braun & Clarke, 2006, 2013). The analysis was underpinned by a critical-realist ontology, assuming the existence of a meaningful reality while acknowledging the impact of factors such as participants' culture and language on the experience and expression of this (Ussher, 1999). *Skype* and telephone interviews were orthographically transcribed. Email and IM interviews, already in textual form, were copied verbatim into a datafile. These data were not edited other than correcting self-evident typos for ease of reading.

As data collection took place over a protracted length of time, coding began before the full dataset was available. Coding and analysis were led by the first author and guided by Braun and Clarke's (2006, 2013) approach to TA. Initially, transcripts were read and re-read, and notes made. Transcripts were then read closely and initial coding labels were written alongside in the margins. Codes were refined and added to as interviews were revisited over time. The second author coded three interviews and we discussed and reflected on differences in coding and this discussion informed the first author's ongoing coding of the data. Once coding was complete, the first author developed larger patterns across the dataset and grouped the codes into potential themes (Braun & Clarke, 2006), striving to allow a relatively inductive approach unsteered by previous research and definitions.

The first author made a 'directory' of themes accompanied by the related participant quotations, making it possible to review themes and consider their faithfulness to the data. Writing was an integral part of the analysis (Braun & Clark, 2013), helping to finalise theme structure and boundaries. Table 1 provides an overview of the thematic structure.

[insert Table 1 about here]

Analysis

The Voice that Permits Picking: Cognitions Drive Picking and Undermine Resistance

Throughout the interviews, participants described conflict between the drive to pick and to stop, sometimes describing it as a '*running argument'* (Marcus) or '*battle'* (Olivia) between separate voices or '*minds'* (Melanie). This theme describes how participants rationalised, justified and permitted their picking in the moment, despite the distress that often followed.

Skin Texture Must Go

Cognitive processes, such as thoughts and attention focussed on the skin, seemed to both trigger picking and make it difficult to stop once started. Participants unanimously described the want to smooth skin texture as an immediate precipitator of picking and saw resulting skin damage as unintentional, collateral harm. Julie described how her desire to smooth texture meant that her skin could not heal:

> *When the skin that's been picked goes hard, I'm compelled to pull at that too, because I hate the feel of lumps or unevenness on my fingers. This means the worst wounds are pretty much never healed.*

While a few participants considered there were *'no thought process to it'* (Rebecca), others considered texture *'not acceptable'* (Melanie) or '*gross'* (Sam), and some implied that texture was unhygienic by using words such as '*cleaning'* (Annie, Lisa) to describe picking. Some described how scrutinising social experiences made them '*more alert for imperfections'* (Ellen), and some suggested that others had instilled in them a negative meaning to skin texture, such as through bullying or encouragement to pick. Participants viewed these cognitions with critical distance when not picking, acknowledging that they did not *'reflect reality'* (Olivia) and that picking achieved '*the opposite'* (Eden) of their intentions.

Many described picking to involve a '[*detailed] level of focus'* (Ellen) that maximised sensory information about the skin and caused them to '*see something else'* (Olivia), perpetuating picking. Several participants described attempts to moderate picking by reducing this sensory information (as with 'stimulus control' techniques; e.g. Jafferany & Patel, 2019), though participants' motivation to pick often overcame these barriers as they '*cheated'* (Lucy) or '*relented'* (Rebecca).

Another route whereby picking continued seemed to be a draw to having picked to a finite point, such as '*when something comes out'* (Leanne) or '*all uneven surfaces are gone'* (Sky). It was not always clear whether these cognitions were separate from the general motivation to smooth skin (someone set against texture may want to remove all rather than some), but some seemed motivated specifically by a sense of completion. Sky explained that '*I'll end up carrying on because it's like I've not finished'*, and Lisa described satisfaction in feeling '*really diligent'* when picking her skin completely and '*perfectly'*. The appeal of completion logically seems related to the idea that incompleteness may be uncomfortable for people with SP (Snorrason, 2016).

'Oh Well' and 'So What': Resignation to Picking

Several participants described cognitions permitting picking that were characterised by resignation or a lack of resistance to it. Rebecca explained that she would '*have to pick it sooner or later, so I might as well get it over and done with'*, suggesting that she considered picking inevitable and resistance as futile. Others diminished the significance or impact of damage from picking, such as where skin was already disliked or damaged from previous picking. Jenny related the start of her picking to dislike for her body, recalling '*so what to it if it was going to make my legs look a mess, because nothing would have made me like my body so why not do something that could cause scars or whatever'*. Jeff similarly connecting feelings of low self-worth to a resigned acceptance of picking:

> *I'm feeling down at the moment, being hard on myself so I start picking… I think I take out my frustration about feeling low by picking or biting myself. It's almost like I don't matter so if I hurt myself that's fine.*

A few participants picked more or more aggressively at hidden areas of the body where *'no one will ever see [the damage]'* (Lisa), suggesting that concealable damage was more tolerable. This echoes Rehm et al.'s (2015) qualitative study of hair pulling which found that permission-giving thoughts were common, and one participant described how the ability to conceal bald areas "triggers off the urge" (p. 221). A couple of participants in the current study described purposefully planning activities that exposed their skin to others as an incentive to stop picking.

Some described picking as being acceptable where manageable; this was particularly apparent in how picking often *wasn't* allowed where it was *un*manageable. For example, Marcus talked about how he '*steers clear of my legs now'* due to infection and ulceration, implying that this damage was a deterrent, whereas more moderate damage was manageable and harder to resist.

Picking Because I Can: Permissive Circumstances

Picking was often described as a 'default' behaviour, gravitated towards where it could be accommodated or where measures were not actively taken to resist it. Leanne considered that '*if I'm in a situation where I can, then I do'*, suggesting that being 'able' to pick was a direct predictor for picking, and Sam explained that '*if im not distracted by something else then i am [picking] or thinking about picking*'. Several participants described picking more when bored, where picking offered *'something for my hands to do'* (Rebecca). Participants similarly described picking less when busy, either due to distractions or having fewer opportunities to pick, and a couple of participants deliberately limited their free time to reduce opportunities for picking. Previous research into 'habit disorders' notes that habits increase in times of passivity or waiting, speculating that this relates to unoccupied hands (O'Connor et al., 2003).

Two alternative explanations were given for the relationship between boredom and picking. Firstly, Aisha felt that picking offered relief from boredom as a positively uncomfortable experience, by similar means that picking relieved stress (see below). Secondly, Olivia associated boredom with being alone, feeling that a lack of social company allowed her to become more '*self-focussed',* increasing her picking. Both typical and problematic picking are reported to occur largely in private (Bohne et al., 2002) and in situations of reduced socialisation (O'Connor et al., 2003), and visibility to others seems to inhibit picking (see previous subtheme). Additionally, social connection may mediate emotional regulation (e.g. Seppala et al., 2013) and isolation may increase self-defeating and addictive behaviours (Hari, 2015; Twenge & Baumeister, 2005). although research has identified boredom as a precipitant of picking (e.g. Bohne et al., 2002), to our knowledge the mechanisms of this relationship have not been explored.

Switching Everything Else Off

This theme describes how participants' reported picking to have dissociative qualities that offered emotional and mental relief.

Zoning In to Zone Out

Over half of the participants described intense attention on the process of picking, using words such as '*entranced'* (Annie) and '*pure focus'* (Marcus) to describe how their attention was consumed. Melanie explained that '*in that moment in time nothing else matters apart from what your picking and where your picking'.* This idea of focus seems to relate to Wilhelm et al.'s (1999) use of the word 'mesmerized' and Deckersbach et al.'s (2003) description in their case study of "zooming in" (p. 255) in front of the mirror, and seems implicit in a 'focussed' style of picking (Walter et al., 2009). The current participants' descriptions also seem evocative of Heatherton and Baumeister's (1991) description of 'cognitive narrowing' during binge eating, whereby individuals narrow "the focus of [their] attention to the present and immediate stimulus environment" (p. 88).

Where attention is focussed on picking, it correspondingly disconnected from other thoughts and senses. This zoning out or '*trance state*' (Melanie) has been briefly mentioned in research relevant to SP (e.g. Wilhelm et al., 1999). In the current study, zoning out was mentioned by almost all participants. Lisa explained:

> *I feel like I'm just switching everything else off… it's all about the picking when I'm picking, it's not about anything else… it's blocking everything out for a minute. It's like putting the pause button on almost, stopping the world*

Julie described how '*there can be trance-like times when I lose track of time picking at my head'* and Annie *described* '*rarely [feeling] any sort of pain'*. This disconnect was sometimes implicit in descriptions of suddenly realising the extent of picking.

Participants' disconnect was sometimes indicative of depersonalisation. Ellen forgot that '*what I'm doing is attached to my actual face'* and Lisa said that her skin '*may as well be something lying next to me'*, seemingly considering their skin as object rather than a living subject. This corresponds with theories in body dysmorphia that suggest attention to be consumed by the body's object image at the expense of bodily senses (Veale, 2004). It may be that disconnect from awareness time, pain and subjectivity reduces access to motivation to stop picking, as has been similarly suggested in binge eating (Heatherton & Baumeister, 1991).

The extent of disconnect varied across participants. Some described access to thoughts about stopping picking, creating an internal argument or '*battle'* (Olivia) between separate voices or different '*bit[s] of my brain*' (Leanne). Melanie gave words to her two perspectives:

> *I would say I have two minds when I'm in that trance like state [picking], it's like I have an angel and a devil, the angel is telling me to stop picking I'm only making it worse and that it's hurting me I have to stop and then there's the devil telling me to keep going look how much you've picked and how much stuff you've got out your skin it makes me feel better, I'm usually bleeding a lot before I'll convince myself that it's time to stop and step away…*

Thoughts about stopping were often outcompeted by the drive to pick and did not translate into action: '*During [picking], I quite often realise I'm doing it and will tell myself to stop but won't physically be able to snap myself out of it'* (Eden).

Discussion of attention is complicated by subtleties, changes and contradictions within participants' descriptions, captured in Ellen's portrayal of being '*entirely absorbed on one level, klaxons going off on another*'. Participants' consciousness, thoughts and awareness during picking were clearly not simple nor singular experiences.

It Comes with Negative Emotions

Uncomfortable emotions, most often those carrying a nervous energy such as stress or anxiety, were described by all but one participant as increasing picking frequency and/or aggression. Many considered or suspected picking to be in part a response to deeper or broader emotional issues, with several connecting picking to traumatic experiences such as bullying, loss and abuse. Lucy considered her worst picking to have been '*a symptom of the distress, despair and utter hopelessness'* that she felt when subject to an abusive relationship, and Leanne suspected that her picking was '*a symptom of that anxiety, the restlessness, the feeling of never being truly peaceful'* following a traumatic loss. Marcus described how the stress of picking damage itself precipitated further cycles of picking: *'[picking damage makes me] feel a burden, waste of space, and it perpetuates the cycle all over again'*. This impact of emotion on picking corresponds with the findings of previous research (e.g. Neziroglu et al., 2008; Roberts et al., 2015) and the notion that stress increases risky and instinctively driven decision making (Starcke & Brand, 2012). Some participants suggested that positive systemic change (such as changes in relationships) or stress management helped to reduce picking, though picking often persisted having become a problem *'in its own right'* (Marcus), leaving participants with '*more of a habit'* (Helen).

Reducing Emotional and Mental Noise

Participants connected emotion and picking in several ways, such as that stress caused more self-touching, which meant more texture was noticed, or that mood impacted how imperfections were appraised. The most common connection was that the trance state of picking served an emotional function by giving respite from thoughts and feelings. Participants described picking as a '*reliever'* (Sky) and as '*therapeutic'* (Jenny). Lucy, who considered her picking to be a stimming behaviour associated with autism, explained how her picking reduced overwhelm:

> *When I'm in an environment with bright lights and lots of people talking (and this gets amplified greatly by stress and/or tiredness) – everything is just too much and I guess the stimming (which the biting/picking [at skin] is part of) redirects my attention onto something I can handle when I can't handle the world around me.*

This perspective echoes the stimulus regulation model of hair pulling, where hair pulling is considered an attempt to balance senses and stress (Penzel, 2003). Similar theories have been proposed for autistic people, where repetitive behaviours may regulate sensory overload and uncontainable emotion (Kapp, et. al., 2019). Marcus vividly described the calming effect of picking:

> *My thought process [when overwhelmed] becomes like a carousel at the fair, blurred images whizzing past my eyes unable to pick a thought and hold it down long enough to process it. Then in the madness the only thing that quietens the mayhem is picking. The act of picking focuses my mind in a singular thought and task, giving my brain a much needed break from itself…*

This zoning out helped participants to forget about *'whatever else is going on'* (Jenny) and '*take a break from life'* (Sky), using similar language to a participant in Rehm et al.'s (2015) study who described hair pulling as "a break from thinking" (p. 219). Lisa suggested that picking allowed her to better process her thoughts and let '*the experiences of the day just sort of filter through'*. Around a third of participants described picking as a coping behaviour, such as that it '*helped me out of what I needed to be out of at the time'* (Aisha). Several considered picking to be preferable to 'alternatives' such as self-injury and smoking.

I Worry About People Looking and Judging Me: Distress in How Picking is Seen

While the direct consequences of picking (such as pain and loss of time) were problematic and distressing, distress relating to beliefs about the appearance of picking in the eyes of others was powerful across the interviews.

Shame of Picking

Shame and self-consciousness about the appearance of picking damage and/or behaviour was present to varying degrees across all interviews. For some, the appearance of damage was their primary, if not only, concern; Ellen remarked that '*if it didn't leave a mark I genuinely wouldn't care in the slightest'.* Concerns about others' thoughts or judgement were sometimes more implicit, such as in efforts to conceal damage or avoid exposing activities. Helen described not answering the door after '*a bad pick*', explaining that '*if I do have to go out my anxiety is through the roof… [I worry about] people looking and judging me… wondering what is wrong with me'.* For some, shame focussed on the aesthetic appearance of picking damage, which made them feel or look unattractive. Others feared that skin damage would be mistaken for disease or something contagious, corresponding with thinking about stigma relating to pathogen avoidance (e.g. Kurzban & Leary, 2001) and echoing the experience of people living with skin conditions (Hrehorów et al., 2012; Kellet & Gilbert, 2001).

For some, the problem with the damage was that it revealed the act of picking, which all participants wanted to hide to some extent and Jenny called a '*dirty little secret*'. Very few participants articulated specific cognitions relating to their shame. Those that did suggested picking to be childish, appear unprofessional, reflect poorly on their self-care or represent a lack of self-control. This latter point was evident in how several participants described making '*excuses'* (Rebecca) for damage, suggesting that accidental damage would be less shameful. Leanne made this point explicitly:

> *It's not something that has happened to me by accident that was out of my control, I wouldn't be ashamed then, so it's got to be that it's something I've physically done to myself and I'm ashamed that I haven't been in control of myself enough to not do it.*

I am Misunderstood

Many participants expressed frustration that others advised them to 'just stop' picking, feeling that their picking was misunderstood as being easy to stop. Jeff found these comments shaming as it was *‘like it’s something I should be able to control and is easy for me to stop doing’,* suggesting that picking was seen by others to reflect a weak will. Bradley and Ecks’ (2018) study of family relationships alongside hair pulling similarly described parents commenting “why can’t you just stop?” (p. 572), serving to only increase family tensions and hair pulling. In the current study, several participants also expressed frustration that picking was considered a ‘habit’, a word seeming to diminish the complexity and tenacity of picking.

Feeling misunderstood was often silencing. Participants often felt that talking about picking risked negative judgement or that a lack of understanding made conversations ‘*more hassle than [they’re] worth*’ (Rebecca). Many were reluctant to seek professional support and past help-seeking experiences were mixed; some told positive stories of professionals recognising their distress and working to understand them, while others, such as Jenny, described feeling dismissed:

> *I saw a psychiatrist and when I mentioned it to him and showed my legs to him he pretty just ignored what I said and started talking about something else! … it was annoying because to me it is a problem, yet he just made it seem like it was just nothing… I'd just like them to take it seriously, rather than making me feel like I'm just being silly and it's not a problem at all.*

It was common for participants to feel that helping professionals should have a pre-existing understanding of picking, considering that this would aid treatment, help them *‘to be understood’* (Olivia) and mean that SP would be treated *‘as a serious issue’* (Leanne). This demonstrates the power of the clinician and how a response lacking in understanding may be shaming (Lazare, 1987).

Discussion

The current study explores three themes in the problematic experience of SP, each suggesting opportunities for therapeutic intervention and support.

‘*The Voice that Permits Picking’* considers the cognitions that many participants identified as driving their picking or weakening their resistance, as well as the environmental factors (e.g. being alone, sedentary activity) that permitted picking. It seems imperative that therapists are prepared to support individuals to understand and manage this immediate drive to pick. This drive to pick has been the central target for previously suggested therapies such as Habit Reversal Therapy, Cognitive Behavioural Therapy (CBT) and Acceptance and Commitment Therapy (ACT) (e.g. Schuck et al., 2011; Twohig et al., 2006), which have aimed to recondition, restructure or loosen the impetus to pick, though discussion of the cognitions and behaviours that may be targeted is limited (e.g. Deckersbach et al., 2002). Findings from the current study suggest patterns in participants’ cognitions, such as that (paraphrased) ‘texture is unacceptable’, ‘I need to get it all’, ‘it’s going to happen eventually’ and that ‘the damage doesn’t matter’ (either ‘it won’t be seen’ or ‘I didn’t like my body anyway’).

These thoughts often seemed influenced by factors such as social experiences, attention, sensory information, how much the body or self was valued, self-focus, inoccupation or the ability to conceal damage. An understanding of these precipitants may be particularly helpful for therapists developing interventions seeking to reduce picking. For example, having time and space to pick may be targeted by behavioural interventions intending to fill time positively or engage socially at triggering times. 'I didn't like my body anyway' might warrant an exploration of their relationship with their body, and benefit from interventions to grow self-compassion and esteem. Picking because of the ability to hide damage may be sensitively challenged by goals to stop hiding, as used by Deckersbach et al. (2002) in an individual's treatment.

'Switching Everything Else Off' explores how the attentional experience of picking offered escape from emotion and overwhelm. This locates possible problems in contextual emotion and overwhelm (suggesting that contextual emotion or systemic factors may be considered in therapy), and/or in picking's use as a problematic coping mechanism (suggesting that it may be helpful for therapy to strengthen alternative coping strategies), and suggests that failure to address emotion or develop healthy coping risks picking being replaced with alternative unhealthy strategies. While SP has been previously suggested to have an emotional function (Flessner & Woods, 2006), the mechanisms of relief have not to our knowledge been explored. Participants in the current study give rich descriptions of this experience, suggesting that focus on the repetitive and satisfying task of picking may facilitate zoning out away from competing thoughts and stress. An understanding of these processes may be helpful for therapists when considering which alternative coping strategies might offer similar relief (such as those involving repetitive, rewarding behaviour). The analysis presents similarities in descriptions of self-regulation in SP and autistic stimming (see Kapp et al., 2019), though this observation is preliminary and requires further exploration.

'*I Worry About People Looking and Judging Me'* highlights shame and the real or imagined perspectives of others as significant in picking distress. When considered alongside the two other themes, this distress may drive further picking by increasing self-criticism and thus strengthening permission giving cognitions, as well as increasing the alure of a zoned-out headspace. As well as impacting on quality of life, social avoidance relating to shame may also increase factors such as aloneness or boredom that may precipitate or accommodate picking. Despite the apparent centrality of distress in the problematic experience of SP, treatments have largely targeted the *urge* to pick (e.g. Schuck et al., 2011; Flessner et al., 2008). It seems imperative that therapists might also consider distress as itself a target of therapy; a reduction in distress, as well itself being positive, may also weaken the mechanisms and cycles that drive or exacerbate SP. Distress in the current study related significantly to appearance; Clarke et al. (2014) recommend applying CBT principles to appearance-related distress and the cycles that maintain it, and ACT may also be useful for working with issues relating to visible difference (e.g. Shepherd et al., 2019; Zucchelli et al., 2018).

The centrality of shame in SP distress, and its interpersonal nature, implicate the role of the therapist in ameliorating or worsening distress. The current study shows how dismissive professionals may be shaming and silencing, suggesting that empathy for and acceptance of SP behaviours and distress may be powerful therapeutic tools. The current study reports self-objectification, depersonalisation and aesthetic self-criticism in the experience of SP. This underlines the importance of the therapist not objectifying the client, such as by viewing the skin solely as an object to be fixed, and the imperative of seeing and welcoming the client's whole subjectivity, including the side of them that is drawn to picking. It may also be helpful to build social support within understanding communities, such as the online groups that many of the current study's participants praised, or as group psychotherapy as recommended by Nakell (2015).

Conclusion

This study offers insight into the mechanisms of picking's appeal, tenacity and distress. It presents SP not simply as a problem of drive and behaviour, but one of emotional context and consequence. The complexity of participants' experiences suggests that cases may be best understood by considering and responding to what is meaningful to the individual. The transdiagnostic fields of appearance, shame and body shame, impulsivity and emotion regulation may flexibly inform this work. Non-judgemental therapy that accepts all elements of the individual, including those which the individual rejects, may provide the space needed to develop insight into SP.

Table 1

Thematic structure

Theme title	***Summary***	***Sub-themes***
The Voice that Permits Picking: Cognitions Drive Picking and Undermine Resistance	Participants' picking behaviour was driven by cognitions and circumstances that permit or accommodate picking, and that diminish the will to stop.	• Skin Texture Must Go • 'Oh Well' and 'So What': Resignation to Picking • Picking Because I Can: Permissive Circumstances
Switching Everything Else Off	Participants described their picking as having dissociative qualities. Picking often occurred alongside feelings of stress or distress, and the experience of 'zoning out' offered by picking gave participants relief.	• Zoning In to Zone Out • It Comes with Negative Emotions • Reducing Emotional and Mental Noise
I Worry About People Looking and Judging Me: Distress in How Picking is Seen	Much of participants' distress seemed mediated by beliefs about the appearance of picking and its damage in the eyes of others. Participants were self-conscious of picking damage and felt that their picking was misunderstood by others.	• Shame of Picking • I am Misunderstood

References

Abramovitch, A., Berman, N., Calkins, A., & Wilhelm, S. (2015). Obsessive-Compulsive and related disorders. In P. H. Blaney, R. F. Krueger & T. Millon (Eds.), *Oxford Textbook of Psychopathology* (3rd ed., pp. 163-190). Oxford University Press.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental Disorders* (5th ed.). American Psychiatric Association.

Anderson, S., & Clarke, V. (2019). Disgust, shame and the psychosocial impact of skin picking: Evidence from an online support forum*. Journal of Health Psychology, 24*(13), 1773-1784. https://doi.org/10.1177%2F1359105317700254.

Arnold, L. M., Auchenbach, M. B., & McElroy, S. L. (2001). Psychogenic excoriation: Clinical features, proposed diagnostic criteria, epidemiology and approaches to treatment. *Central Nervous System Drugs, 15*(5), 351-359. https://doi.org/10.2165/00023210-200115050-00002

Arnold, L. M., McElroy, S. L., Mutasim, D. F., Dwight, M. M., Lamerson, C. L., & Morris, E. M. (1998). Characteristics of 34 adults with psychogenic excoriation. *Journal of Clinical Psychiatry, 59*(10), 509-514. https://doi.org/10.4088/jcp.v59n1003

Bohne, A., Keuthen, N. J., & Wilhelm, S. (2005). Pathologic hairpulling, skin picking, and nail biting. *Annals of Clinical Psychiatry, 17*(4), 227-232.

Bohne, A., Wilhelm, S., Keuthen, N. J., Baer, L., & Jenike, M. A. (2002). Skin picking in German students: Prevalence, phenomenology, and associated characteristics. *Behavior Modification, 26*(3), 320-339. https://doi.org/10.1177%2F0145445502026003002

Bradley, B., & Ecks, S. (2018). Disentangling Family Life and Hair Pulling: Trichotillomania and Relatedness. *Medical Anthropology, 37*(7), 568-581. https://doi.org/10.1080/01459740.2018.1476509

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners.* Sage.

Capriotti, M. R., Ely, L. J., Snorrason, I., & Woods, D. W. (2015). Acceptance-enhanced behavior therapy for excoriation (skin-picking) disorder in adults: A clinical case series. *Cognitive and Behavioral Practice, 22*(2), 230-239. https://doi.org/10.1016/j.cbpra.2014.01.008

Castles, D. L., Whiten, A., & Aureli, F. (1999). Social anxiety, relationships and self-directed behaviour among wild female olive baboons. *Animal Behaviour, 58*(6), 1207-1215. https://doi.org/10.1006/anbe.1999.1250

Clarke, A., Thompson, A. R., Jenkinson, E., Rumsey, N., & Newell, R. (2014). *CBT for appearance anxiety: Psychosocial interventions for anxiety due to visible difference*. John Wiley & Sons.

Cosgrove, L., & Krimsky, S. (2012). A comparison of DSM-IV and DSM-5 panel members' financial associations with industry: a pernicious problem persists. *PLoS Medicine, 9*(3), e1001190. https://doi.org/10.1371/journal.pmed.1001190

Deckersbach, T., Wilhelm, S., & Keuthen, N. (2003). Self-injurious skin picking: Clinical characteristics, assessment methods and treatment modalities. *Brief Treatment and Crisis Intervention, 3*(2), 249-260. https://triggered.edina.clockss.org/ServeContent?url=http://btci.stanford.clockss.org%2Fcgi%2Freprint%2F3%2F2%2F249.pdf

Deckersbach, T., Wilhelm, S., Keuthen, N. J., Baer, L., & Jenike, M. A. (2002). Cognitive-behavior therapy for self-injurious skin picking: A case series. *Behavior Modification, 26*(3), 361-377. https://doi.org/10.1177/0145445502026003004

DeYoung, P.A. (2015). *Understanding and treating chronic shame: A relational/neurobiological approach*. Routledge.

Dunbar, R. I. M. (2010). The social role of touch in humans and primates: behavioural function and neurobiological mechanisms. *Neuroscience & Biobehavioral Reviews, 34*(2), 260-268. https://doi.org/10.1016/j.neubiorev.2008.07.001

Flessner, C. A., Busch, A. M., Heideman, P. W., & Woods, D. W. (2008). Acceptance-enhanced behavior therapy (AEBT) for trichotillomania and chronic skin picking: Exploring the effects of component sequencing. *Behavior Modification, 32*(5), 579-594. https://doi.org/10.1177%2F0145445507313800

Flessner, C. A., & Woods, D. W. (2006). Phenomenological characteristics, social problems, and the economic impact associated with chronic skin picking. *Behavior Modification, 30*(6), 944-963. https://doi.org/10.1177%2F0145445506294083

Gallinat, C., Moessner, M., Haenssle, H. A., Winkler, J. K., Backenstrass, M., & Bauer, S. (2019). Help-seeking attitudes and experiences in individuals affected by skin picking. *Journal of Obsessive-Compulsive and Related Disorders, 23*, 100483. https://doi.org/10.1016/j.jocrd.2019.100483

Gibson, L. (2017). Generating interview data via email. In V. Braun, V. Clarke, & D. Gray (Eds.), *Collecting qualitative data: A practical guide to textual, media and virtual techniques* (pp. 213-234). Cambridge University Press.

Grant, J. E., Leppink, E., & Chamberlain, S. (2015). Body focused repetitive behavior disorders and perceived stress: Clinical and cognitive associations. *Journal of Obsessive-Compulsive and Related Disorders, 5*, 82-86. https://doi.org/10.1016/j.jocrd.2015.02.001

Grant, J. E., Redden, S. A., Leppink, E. W., Odlaug, B. L., & Chamberlain, S. R. (2016). Psychosocial dysfunction associated with skin picking disorder and trichotillomania. *Psychiatry Research, 239*, 68-71. https://doi.org/10.1016/j.psychres.2016.03.004

Gupta, M. A., Gupta, A. K., & Schork, N. J. (1996). Psychological factors affecting self-excoriative behavior in women with mild-to-moderate facial acne vulgaris. *Psychosomatics, 37*(2), 127-130. https://doi.org/10.1016/S0033-3182(96)71578-5

Hanna, P. & Mwale, S. (2017). Virtual face-to-face interviewing. In V. Braun, V. Clarke, & D. Gray (Eds.), *Collecting qualitative data: A practical guide to textual, media and virtual techniques* (pp. 256-274). Cambridge University Press.

Hari, J. (2015). *Chasing the scream: The first and last days of the war on drugs*. Bloomsbury.

Heatherton, T. F., & Baumeister, R. F. (1991). Binge eating as escape from self-awareness. *Psychological Bulletin, 110*(1), 86-108. https://doi.org/10.1037/0033-2909.110.1.86

Hrehorów E, Salomon J, Matusiak L, Reich A, & Szepietowski J. C. (2012) Patients with psoriasis feel stigmatized. *Acta Dermato-venereologica, 92*(1), 67–72. https://doi.org/10.2340/00015555-1193

Jafferany, M., & Patel, A. (2019). Skin-picking disorder: A guide to diagnosis and management. *CNS drugs, 33*(4), 337-346. https://doi.org/10.1007/s40263-019-00621-7

Kapp, S. K., Steward, R., Crane, L., Elliot, D., Elphick, C., Pellicano, E., & Russel, G. (2019). 'People should be allowed to do what they like': Autistic adults' views and experiences of stimming. *Autism, 23*(7), 1782-1792. https://doi.org/10.1177/1362361319829628

Kaufman, G. (1996). *The psychology of shame: Theory and treatment of shame-based syndromes* (2nd ed.). Springer Publishing Company.

Kellett, S., & Gilbert, P. (2001). Acne: A biopsychosocial and evolutionary perspective with a focus on shame. *British Journal of Health Psychology, 6*(1), 1-24. https://doi.org/10.1348/135910701169025

Keuthen, N. J., Deckersbach, T., Wilhelm, S., Engelhard, I., Forker, A., O'Sullivan, R. L., Jenike, M. A. & Baer, L. (2001). The skin picking impact scale (SPIS): Scale development and psychometric analyses. *Psychosomatics, 42*(5), 397-403. https://doi.org/10.1176/appi.psy.42.5.397

Keuthen, N. J., Deckersbach, T., Wilhelm, S., Hale, E., Fraim, C., Baer, L., O'Sullivan, R. & Jenike, M. A. (2000). Repetitive skin-picking in a student population and comparison with a sample of self-injurious skin-pickers*. Psychosomatics, 41*(3), 210-215. https://doi.org/10.1176/appi.psy.41.3.210

Keuthen, N. J., Koran, L. M., Aboujaoude, E., Large, M. D., & Serpe, R. T. (2010). The prevalence of pathologic skin picking in US adults*. Comprehensive Psychiatry, 51*(2), 183-186. https://doi.org/10.1016/j.comppsych.2009.04.003

Kurzban, R., Leary, M. R. (2001). Evolutionary origins of stigmatization: The functions of social exclusion. *Psychological Bulletin, 127*(2), 187–208. https://psycnet.apa.org/buy/2001-16969-001

Lazare, A. (1987). Shame and humiliation in the medical encounter. *Archives of Internal Medicine, 147*(9), 1653-1658. doi:10.1001/archinte.1987.00370090129021

Lincoln, Y. S., & Guba, E. G. (1985). Establishing trustworthiness. *Naturalistic Inquiry, 289*(331), 289-327.

Machado, M. O., Köhler, C. A., Stubbs, B., Nunes-Neto, P. R., Koyanagi, A., Quevedo, J., Soares, J. C., Hyphantis, T. N., Marazziti, D., Maes, M., Stein, D. J., & Carvalho, A. F. (2018). Skin picking disorder: prevalence, correlates, and associations with quality of life in a large sample. *CNS spectrums, 23*(5), 311-320. https://doi.org/10.1017/S1092852918000871

Maestripieri, D., Schino, G., Aureli, F., & Troisi, A. (1992). A modest proposal: displacement activities as an indicator of emotions in primates. *Animal Behaviour, 44*(5), 967-979. https://doi.org/10.1016/S0003-3472(05)80592-5

Mohiyeddini, C., & Semple, S. (2013). Displacement behaviour regulates the experience of stress in men. *Stress, 16*(2), 163-171. https://doi.org/10.3109/10253890.2012.707709

Nakell, S. (2015). A healing herd: Benefits of a psychodynamic group approach in treating body-focused repetitive behaviors. *International Journal of Group Psychotherapy, 65*(2), 295-306. https://doi.org/10.1521/ijgp.2015.65.2.295

Neziroglu, F., Rabinowitz, D., Breytman, A., & Jacofsky, M. (2008). Skin picking phenomenology and severity comparison. *Journal of Clinical Psychiatry, 10*(4), 306-312. https://dx.doi.org/10.4088%2Fpcc.v10n0406

O'Connor, K., Brisebois, H., Brault, M., Robillard, S., & Loiselle, J. (2003). Behavioral activity associated with onset in chronic tic and habit disorder. *Behaviour Research and Therapy, 41*(2), 241-249. https://doi.org/10.1016/S0005-7967(02)00051-7

Odlaug, B. L., & Grant, J. E. (2007). Childhood-onset pathologic skin picking: Clinical characteristics and psychiatric comorbidity. *Comprehensive Psychiatry, 48*(4), 388-393. https://doi.org/10.1016/j.comppsych.2007.03.007

Odlaug, B. L., & Grant, J. E. (2008). Clinical characteristics and medical complications of pathologic skin picking. *General Hospital Psychiatry, 30*(1), 61-66. https://doi.org/10.1016/j.genhosppsych.2007.07.009

Odlaug, B. L., & Grant, J. E. (2010). Pathologic skin picking. *American Journal of Drug and Alcohol Abuse, 36*(5), 296-303. https://doi.org/10.3109/00952991003747543

Özten, E., Sayar, G. H., Eryılmaz, G., Kağan, G., Işık, S., & Karamustafalıoğlu, O. (2015). The relationship of psychological trauma with trichotillomania and skin picking. *Neuropsychiatric Disease and Treatment, 11*, 1203-1210. https://doi.org/10.2147/NDT.S79554

Pearce, S. (2014). DSM-5 and the rise of the diagnostic checklist. *Journal of Medical Ethics, 40*(8), 515-516. http://dx.doi.org/10.1136/medethics-2013-101933

Penzel, F. (2003). *The hair-pulling problem: A complete guide to trichotillomania*. Oxford University Press.

Perrykkad, K., & Hohwy, J. (2020). Fidgeting as self-evidencing: A predictive processing account of non-goal-directed action. *New Ideas in Psychology, 56*, 100750. https://doi.org/10.1016/j.newideapsych.2019.100750

Prochwicz, K., Kałużna-Wielobób, A., & Kłosowska, J. (2016). Skin picking in a non-clinical sample of young Polish adults. Prevalence and characteristics. *Comprehensive Psychiatry, 71*, 77-85. https://doi.org/10.1016/j.comppsych.2016.08.013

Rehm, I. C., Nedeljkovic, M., Thomas, A., & Moulding, R. (2015). The role of cognitions and beliefs in trichotillomania: A qualitative study using interpretative phenomenological analysis. *Behaviour Change, 32*(4), 209-230. https://doi.org/10.1017/bec.2015.11

Roberts, S., O'Connor, K., & Bélanger, C. (2013). Emotion regulation and other psychological models for body-focused repetitive behaviors. *Clinical Psychology Review, 33*(6), 745-762. https://doi.org/10.1016/j.cpr.2013.05.004

Roberts, S., O’Connor, K., Aardema, F., & Belanger, C. (2015). The impact of emotions on body focussed repetitive behaviours: Evidence from a non-treatment seeking sample. *Journal of Behaviour Therapy and Experimental Psychiatry, 46,* 189-197. https://doi.org/10.1016/j.jbtep.2014.10.007

Schuck, K., Keijsers, G. P. J., & Rinck, M. (2011). The effects of brief cognitive-behaviour therapy for pathological skin picking: A randomized comparison to wait-list control. *Behaviour Research and Therapy, 49*(1), 11-17. https://doi.org/10.1016/j.brat.2010.09.005

Seppala, E., Rossomando, T., & Doty, J. R. (2013). Social connection and compassion: Important predictors of health and well-being. *Social Research: An International Quarterly, 80*(2), 411-430.

Shepherd, L., Reynolds, D. P., Turner, A., O’Boyle, C. P., & Thompson, A. R. (2019). The role of psychological flexibility in appearance anxiety in people who have experienced a visible burn injury. *Burns, 45*(4), 942-949. https://doi.org/10.1016/j.burns.2018.11.015

Siev, J., Reese, H. E., Timpano, K., & Wilhelm, S. (2012). Assessment and treatment of pathological skin picking. In J. E. Grant & M. N. Potenza (Eds.), *The Oxford handbook of impulse control disorders*. Oxford University Press. https://doi.org/10.1093/oxfordhb/9780195389715.013.0103

Simeon, D., Stein, D. J., Gross, S., Islam, N., Schmeidler, J., & Hollander, E. (1997). A double-blind trial of fluoxetine in pathologic skin picking. *The Journal of Clinical Psychiatry, 58*(8), 341-347. https://www.psychiatrist.com/jcp/ocd/double-blind-trial-fluoxetine-pathologic-skin-picking/

Singer, H. S. (2009). Motor stereotypies. *Seminars in Pediatric Neurology, 16*(2), 77-81. https://doi.org/10.1016/j.spen.2009.03.008

Snorrason, Í. (2016). *Examining heightened sense of incompleteness as a candidate endophenotypic marker for skin picking disorder* (Publication No. 1310) [Doctoral Dissertation, The University of Wisconsin-Milwaukee]. UWM Digital Commons. https://dc.uwm.edu/etd/1310

Snorrason, Í., Belleau, E. L., & Woods, D. W. (2012). How related are hair pulling disorder (trichotillomania) and skin picking disorder? A review of evidence for comorbidity, similarities and shared etiology. *Clinical Psychology Review, 32*(7), 618-629. https://doi.org/10.1016/j.cpr.2012.05.008

Snorrason, Í., Smári, J., & Ólafsson, R. P. (2010). Emotion regulation in pathological skin picking: Findings from a non-treatment seeking sample. *Journal of Behavior Therapy and Experimental Psychiatry, 41*(3), 238-245. https://doi.org/10.1016/j.jbtep.2010.01.009

Starcke, K., & Brand, M. (2012). Decision making under stress: a selective review. *Neuroscience & Biobehavioral Reviews, 36*(4), 1228-1248. https://doi.org/10.1016/j.neubiorev.2012.02.003

Sukhodolsky, D. G., Scahill, L., Gadow, K. D., Arnold, L. E., Aman, M. G., McDougle, C. J., McCracken, J. T., Tiernet, E., Williams White, S., Lecavalier, L., & Vitiello, B. (2008). Parent-rated anxiety symptoms in children with pervasive developmental disorders: Frequency and association with core autism symptoms and cognitive functioning. *Journal of Abnormal Child Psychology, 36*, 117-128. https://doi.org/10.1007/s10802-007-9165-9

Teng, E. J., Woods, D. W., Twohig, M. P., & Marcks, B. A. (2002). Body-focused repetitive behavior problems: Prevalence in a nonreferred population and differences in perceived somatic activity. *Behavior Modification, 26*(3), 340-360. https://doi.org/10.1177%2F0145445502026003003

Troisi, A. (2002). Displacement activities as a behavioral measure of stress in nonhuman primates and human subjects. *Stress, 5*(1), 47-54. https://doi.org/10.1080/102538902900012378

Tucker, B. T. P., Woods, D. W., Flessner, C. A., Franklin, S. A., & Franklin, M. E. (2011). The skin picking impact project: Phenomenology, interference, and treatment utilization of pathological skin picking in a population-based sample. *Journal of Anxiety Disorders, 25*(1), 88-95. https://doi.org/10.1016/j.janxdis.2010.08.007

Twenge, J. M., & Baumeister, R. F. (2005). Social exclusion increases aggression and self-defeating behavior while reducing intelligent thought and prosocial behavior. In D. Abrams, M. A. Hogg, & J. M. Marques (Eds.), *Social psychology of inclusion and exclusion* (pp. 27-46). Psychology Press.

Twohig, M. P., Hayes, S. C., & Masuda, A. (2006). A preliminary investigation of acceptance and commitment therapy as a treatment for chronic skin picking*. Behaviour Research and Therapy, 44*(10), 1513-1522. https://doi.org/10.1016/j.brat.2005.10.002

Ussher, J. M. (1999). Eclecticism and methodological pluralism: The way forward for feminist research. *Psychology of Women Quarterly, 23*, 41-46. https://doi.org/10.1111%2Fj.1471-6402.1999.tb00339.x

Veale, D. (2004). Advances in a cognitive behavioural model of body dysmorphic disorder. *Body image, 1*(1), 113-125. https://doi.org/10.1016/S1740-1445(03)00009-3

Walther, M. R., Flessner, C. A., Conelea, C. A., & Woods, D. W. (2009). The Milwaukee Inventory for the Dimensions of Adult Skin Picking (MIDAS): Initial development and psychometric properties. *Journal of Behavior Therapy and Experimental Psychiatry, 40*(1), 127-135. https://doi.org/10.1016/j.jbtep.2008.07.002

Wilhelm, S., Keuthen, N. J., Deckersbach, T., Engelhard, I. M., Forker, A. E., Baer, O’Sullivan, R. L., & Jenike, M. A. (1999). Self-injurious skin picking: Clinical characteristics and comorbidity. *Journal of Clinical Psychiatry, 60*(7), 454-459. https://www.psychiatrist.com/jcp/medical/comorbidity/self-injurious-skin-picking-clinical-characteristics/

World Health Organization (2020). *International Classification of Diseases for Mortality and Morbidity Statistics* (11th Revision). Retrieved February 20, 2021, from https://icd.who.int/browse11/l-m/en

Zucchelli, F., Donnelly, O., Williamson, H., & Hooper, N. (2018). Acceptance and Commitment

Therapy for people experiencing appearance-related distress associated with a visible difference: A rationale and review of relevant research. *Journal of Cognitive Psychotherapy, 32*(3), 171-183. https://doi.org/10.1891/0889-8391.32.3.171