
A JOURNEY TO AUTHENTICITY:
An Autoethnography of Compulsive
Excoriation (Skin Picking) Disorder

By

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Sincerely, Allison

DISCLAIMERS

MEDICAL/HEALTH DISCLAIMER:

This major research paper cannot and does not contain medical or health advice. Any medical/health content is provided for general informational and educational purposes only and is not a substitute for professional advice or recommendation. Accordingly, before taking any actions based on information shared here, readers are encouraged to consult with the appropriate professionals. Use of or reliance on any information espoused by this project is done solely at the reader's own risk.

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This autoethnographic major research project presents my real-life experiences living with compulsive excoriation (skin picking) disorder. However, every experience is unique. This project does not claim to be, nor should be construed as, a universal experience. It should not be used to diagnose, treat, mitigate, cure, or prevent a medical condition. Should any individual have concerns about their health (mental or physical), they are advised to consult an appropriate health care provider.

ABSTRACT

Compulsive excoriation (skin picking) disorder (CSPD) is an underrecognized mental illness that affects 2-5% of the population. This autoethnography aims to bridge the gap in qualitative research pertaining to CSPD. The research question asks: *How can a deeper understanding of compulsive excoriation (skin picking) disorder be achieved through the exploration of a lived experience?* The objectives were 1) to raise awareness, consolidate knowledge and disprove misconceptions about CSPD; 2) to embark on an emancipatory journey to authenticity; 3) to critically analyze the sociopolitical dynamics inherent in the experience of living with a mental illness in modern-day Western society. These objectives were achieved through the writing and subsequent analyzing of a chronological multilayered autoethnographic account of my lived experience with CSPD. The autoethnographic methodology provides unique access to a deeper understanding of the complexity and paradoxes intrinsic to the day-to-day circumstances of those with CSPD. Based on my analysis, two tables were created with a vision of generating awareness and contributing strategies. The first table can serve as a tool for those living with CSPD. The second table presents strategies for health professionals, loved ones and the public on how to support those living with CSPD. The sociopolitical influence of an immense pressure to succeed, beauty standards, the stigma of mental illness and the intricacies of obtaining mental health diagnoses were discussed in relation to their impact on individuals' lived experience of CSPD.

Keywords: compulsive excoriation (skin picking) disorder, dermatillomania, authenticity, bio-psycho-sociocultural, autoethnography, wounded healer

RESUME

Le trouble d'excoriation (prélèvement de la peau) compulsive (CSPD) est un trouble de santé mentale méconnu qui affecte 2 à 5% de la population. Cette autoethnographie vise à combler un manque dans la production des connaissances entourant le CSPD. La question de recherche était : Comment une compréhension plus approfondie du trouble de l'excoriation compulsive (prélèvement de la peau) peut-elle être obtenue grâce à l'exploration d'une expérience vécue? Les objectifs étaient 1) produire de nouvelles connaissances, réfuter les idées fausses au sujet du CSPD et proposer des outils de sensibilisation ; 2) initier un parcours personnel vers l'authenticité et une meilleure cohabitation avec le CSPD; 3) analyser de manière critique la dynamique sociopolitique de l'expérience de vivre avec un trouble de santé mentale dans une société occidentale contemporaine. Ces objectifs ont été atteints grâce au processus d'écriture d'une expérience vécue et de son analyse. La méthodologie autoethnographique a donné accès à une compréhension approfondie de la complexité et des paradoxes vécus par les personnes qui vivent la CSPD. Sur la base des analyses, deux tableaux ont été créés. Le premier propose des stratégies aux personnes vivant avec le CSPD. Le deuxième tableau se veut un outil pour guider les professionnels de la santé, les proches et le public en lien avec des personnes vivant avec le CSPD. Au niveau sociopolitique, la forte pression de réussite, les normes de beauté, la stigmatisation des troubles de santé mentale et les obstacles à obtenir le diagnostic et les suivis ont été discutés en relation avec leur impact sur l'expérience vécue du CSPD.

Mots-clés : trouble de l'excoriation compulsive (grattages de la peau), authenticité, bio-psycho-socioculturel, recherche qualitative, autoethnographie, *wounded healer*

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	II
DISCLAIMERS.....	IV
MEDICAL/HEALTH DISCLAIMER:.....	IV
PERSONAL EXPERIENCE DISCLAIMER:	IV
ABSTRACT	V
RESUME.....	V
LIST OF ABBREVIATIONS.....	IX
PREFACE.....	1
CHOOSING THE SUITABLE TERM.....	3
TABLE 1.....	4
INTRODUCTION: CONTEXTUALIZING CSPD.....	7
LITERATURE REVIEW.....	11
RESEARCH QUESTION AND OBJECTIVES	18
METHODOLOGY: CHOOSING AUTOETHNOGRAPHY	18
HISTORY AND IMPORTANCE OF AUTOETHNOGRAPHY	19
EMBRACING SUBJECTIVITY THROUGH CREATIVITY.....	21
ANALYSIS.....	24
MY JOURNEY TO LIVING AUTHENTICALLY	25
INTRODUCTION TO THE JOURNEY	25
CHILDHOOD.....	26
PUBERTY-ADOLESCENCE.....	28
MOMENT OF DIAGNOSIS.....	30
THE UNIVERSITY EXPERIENCE.....	32

HEALTH PROFESSIONALS	35
<i>Poetry by Allison Grodinsky</i>	37
<i>HABIT REVERSAL THERAPY GONE WRONG</i>	41
<i>Learning about Intentions</i>	45
PHYSICAL DAMAGE AND PERSONAL COPING STRATEGIES.....	47
<i>Physical Damage: CSPD versus Self-Harm</i>	47
<i>Physical Damage Caused by CSPD</i>	48
<i>My Personal Coping Strategies</i>	50
WORK EXPERIENCE.....	51
<i>Lifeguard / Swimming Instructor 2015 – 2021</i>	52
<i>Social Work Summer Student Intern May 2018 – August 2018</i>	54
ROMANTIC RELATIONSHIPS	56
SUPPORT GROUPS / ONLINE SELF-HELP	60
COVID-19 LOCKDOWN EFFECTS	63
<i>Oh no, I broke a nail! (Dermatillomania edition)</i>	64
SUMMARY OF MY JOURNEY	65
SITUATING MY AUTOETHNOGRAPHY IN A LARGER CONTEXT	66
SOCIETAL NORMS AND EXPECTATIONS:.....	68
NEOLIBERALISM AND THE PRESSURE TO SUCCEED	68
SOCIETAL NORMS AND EXPECTATIONS: BEAUTY STANDARDS	70
<i>Diagnosis: Relief, BURDEN, or both?</i>	71
<i>Stigma of mental illness</i>	74
CSPD AWARENESS AND INTERVENTIONS.....	80
CONCLUSION.....	84
EPILOGUE.....	88
THE ART OF AUTHENTICITY	88

BIBLIOGRAPHY	X
APPENDICES	XVI
APPENDIX A: SKIN PICKING IMPACT SCALE (SPIS)	XVI
APPENDIX B: DERMATILLO-DILLEMMA.....	XVII
APPENDIX C: EMOTIONALLY SCARRED	XX
APPENDIX D: CAPTURING SIMILARITIES AND DIFFERENCES WITHIN THE SKIN PICKING COMMUNITY	XXIV
APPENDIX E: HOLISTIC BIO-PSYCHO-SOCIOCULTURAL STRATEGIES FOR COEXISTING WITH COMPULSIVE EXCORIATION (SKIN PICKING) DISORDER	XXVI
APPENDIX F: FIGURE INSPIRED BY A BIO-PSYCHO-SOCIO-CULTURAL APPROACH.....	XXVIII
APPENDIX G: STRATEGIES FOR HEALTH PROFESSIONALS, LOVED ONES AND THE PUBLIC SUPPORTING INDIVIDUALS	XXIX
LIVING WITH COMPULSIVE EXCORIATION (SKIN PICKING) DISORDER.....	XXIX
APPENDIX H: RESOURCES FOR COMPULSIVE EXCORIATION (SKIN PICKING) DISORDER	XXXI
<i>Book and Article Recommendations.....</i>	<i>xxxii</i>
<i>My Dermatillomania Toolkit.....</i>	<i>xxxiii</i>

LIST OF ABBREVIATIONS

ACT: Acceptance and Commitment Therapy

ADHD: Attention Deficit Hyperactivity Disorder

BFRB: Body-Focused Repetitive Behaviours

CBT: Cognitive Behavioural Therapy

DBT: Dialectal Behavioural Therapy

DSM-5: Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

ERP: Exposure and Response Prevention

GAD: Generalized Anxiety Disorder

HRT: Habit Reversal Training/Therapy

NAC: N-Acetylcysteine

OCD: Obsessive-Compulsive Disorder

CSPD: Compulsive Excoriation (Skin Picking) Disorder / Dermatillomania

SSRI: Selective Serotonin Reuptake Inhibitors

TTM: Trichotillomania (Hair Pulling Disorder)

PREFACE

This paper is inspired by my own experiences with compulsive excoriation (skin picking) disorder (CSPD). I have always wanted to share my story in some capacity to promote awareness about this disorder and help people understand that picking is not simply a bad habit.

In several different spheres of my life, various comments have been made about my skin that have inhibited my progress with my compulsion. Even in my best moments, when my skin was clear—no open wounds, no cuts—and I felt so proud of myself, I still received feedback about the scars left behind. Feelings of shame and hopelessness crept in, since even were I to conquer this disorder, I would forever be left with the external damage from picking thus causing psychosocial challenges. Interactions with family, friends, co-workers, and the public were increasingly difficult, particularly in the summer months, when my scars were fully visible. As all my wounds began to heal, nearly my entire left arm remained overrun with scars resembling bruises.

People would ask about my arm or assume for themselves that I had self-harmed, been beaten, burnt myself, crashed my car, played rugby, the list goes on. I could not be honest as very few people actually know what compulsive excoriation (skin picking) disorder (CSPD) is, and I did not have the energy to explain myself each and every time someone asked, which became an almost daily occurrence. I would hide the truth and say it was a skin condition. I was shocked when even members of the general public would push for further details, so I would answer that the marks were eczema or psoriasis. I purposefully use the phrase “hide the truth” because, while I find it hard to admit, ultimately, I was lying to everyone to protect myself. Protect myself from what exactly? From judgement, shame, embarrassment, and disgust.

Telling these lies made me sick to my stomach. I got a sick feeling every time, but somehow in my mind that was better than telling the truth, as I was convinced no one would understand. However, gradually, the lying became increasingly difficult, and I became more and more irritable and frustrated. Each time someone asked about a scar or made a further assumption, their probing plagued me like a fly that would not leave me alone. I began to feel anger and was annoyed with myself for not being able to tell the truth. Now, as a graduate of a Bachelor of Social Work program and a master's student, I want to practice what I preach. I want to break free of the stigma surrounding mental illness. I am tired of hiding and ready to begin my journey toward becoming my authentic self through the process of self-acceptance and self-compassion for my CSPD.

There has been progress in the realm of general mental health awareness, especially with regard to depression and anxiety. People typically understand that telling someone who is anxious to “just calm down” or someone who is depressed to “just smile and be happy” is not a feasible nor appropriate line of commentary. However, since CSPD has such little awareness, people do not understand that instructing someone with this disorder to “just stop” is not helpful and, in fact, results in being far more triggering. When informing people about my research topic, I have experienced anxiety, along with a sense of shame and discomfort, which forms part of what inspires this endeavor—I would like to stop associating fearful and negative emotions with my disorder. I believe these can be reduced or eliminated by breaking the stigma and providing elucidation of common misconceptions about this disorder.

I have decided to write about this personal part of my life to generate greater awareness and contribute to the limited research that exists. The research thus far indicates very few treatment options. This scarcity of treatment options substantiated by the literature further magnifies the importance of having strong social and professional support systems. Unfortunately, the current

lack of cognizance I have witnessed among friends, family, the general public, and the health professional community has impressed upon me the significance of disseminating information and producing practical tools and resources to address management and recovery

CHOOSING THE SUITABLE TERM

Compulsive excoriation (skin picking) disorder (CSPD) is identified by many different names. Deciding which name to use in this narrational exposition involved an intricate process of reflection. I had to ask myself which term would best correspond with a bio-psycho-sociocultural perspective that could be widely understood.

The lens being utilized in this autoethnography is that of a bio-psycho-sociocultural approach. One aspect that has been influential in cultivating my passion for social work is the unique way in which a problem is analyzed: “the ‘big picture’ approach to care sets the social worker apart from other mental health care professionals, many of whom focus solely on developmental and/or intrapsychic phenomena” (Leight, 2001, p. 64).

The bio-psycho-sociocultural approach truly looks at all the manifold layers and spheres that can play a role in any situation. In other words, an individual’s cognitive, affective, spiritual, and physical states are interrelated elements examined within a multisystemic approach that takes into account environmental, cultural and social dimensions and contexts (Prest & Robinson, 2006).

Bearing this perspective in mind, I took time to reflect and break down each of the discrete terms with which I have interacted throughout both my personal experience and research for this project (see Table 1). Words are important and can articulate different meanings and connotations.

TABLE 1

Glossary of Terms All Describing the Same Disorder	
Compulsive Excoriation (Skin Picking) Disorder	<p>Compulsive: This word puts emphasis on the fact that the skin picking is not voluntary but rather an impulse, or obsession, where one feels compelled to pick their skin.</p> <p>Excoriation (Skin Picking): Excoriation is the medical term for skin picking, which follows in synonymic bracketing. Both diagnostic designations are useful, as the former lends greater credibility to the disorder by making it sound more official.</p> <p>Disorder: This word represents the psychological distress and atypical, extreme aspect of this type or degree of skin picking.</p>
Dermatillomania	<p>Derma: Skin layer</p> <p>Tillo: To pull</p> <p>Mania: Madness (Psychological Disorder)</p>
Excoriation (Skin Picking) Disorder	<p>This is the official term used in the DSM-5. However, it excludes the word “compulsive.”</p> <p>I believe this exclusion to be impolitic, as there is import in highlighting the element of compulsivity and inability to stop voluntarily.</p>
Skin Picking Disorder	<p>Skin Picking: Clearly reflects denotative signification, i.e., to pick at one’s skin.</p> <p>Disorder: In a maladaptive way.</p>

To select a term, I must wrestle with the ways in which I have told people about my disorder—I have not always been consistent with the name I used. At first, I adopted compulsive excoriation disorder as that was the medical diagnosis I was assigned by a dermatologist. However, at the age of 15, that language seemed too technical.

When I found support groups, I learned a new name: dermatillomania. I liked this term because it was similar to trichotillomania¹ and, in my experience, seemed to be a bit more recognizable. “Derma” references skin, “tillo” identifies the act of pulling and “mania” indicates madness or, in other words, the compulsivity of the disorder. That being said, some people would look at me as though I had three heads when I said I had dermatillomania. Thus, I would commonly rephrase with embarrassment and say I had skin picking disorder.

While skin picking disorder is a diagnostic term that can be understood in plain language, it often minimizes the severity of the disorder. Frequently people hear “skin picking” and forget or do not understand that it actually denotes a disorder. For example, they attempt to empathize by sharing, “Oh yeah, I pick my scabs too, sometimes.” At that point, how do I explain, “Hey, no, I actually pick my skin to the point where I bleed, it hurts, and I cannot stop no matter how much I try to stop;” so, normally, instead I end up saying something like, “Oh okay, well, that’s not exactly the same but, yeah, that’s why I have marks on my arm....” People mean well, but do not comprehend how undermining and hurtful uninformed commiserating can be for someone who chronically struggles with this disorder. Therefore, I feel that the denomination of skin picking disorder does not depict the compulsivity nor the severity of the disorder due to the nature of its plain language, which conforms to people’s natural schemas of common self-grooming behaviours.

Excoriation (skin picking) disorder is the official term found in the DSM-5 but I have never used it to describe my disorder. I have always added the word “compulsive” in front of excoriation because 1) that is how I was diagnosed; and 2) I think it represents a key component of the disorder.

¹ Trichotillomania is also known as hair pulling disorder, which “...is characterized by repetitive pulling out of one’s hair (from the scalp, eyebrows, eyelashes or elsewhere on the body)” (Golomb, Franklin, et al., 2016).

I personally prefer both the terms dermatillomania and compulsive excoriation (skin picking) disorder, a partiality which reinforces the quandary of this critical decision re suitability.

Dermatillomania and compulsive excoriation (skin picking) disorder both have their time and place. Dermatillomania is less formal and used more commonly among fellow skin pickers. It is faster to say and is often shortened to “derma.” For example, in support groups members may say, “My derma is so bad right now.” While, less formal, this nomenclature still accurately describes the disorder as defined above with its three morphemic components. Sometimes these three morphemes will help offer people a hint if they are familiar with the disorder’s sister body-focused repetitive behaviour (BFRB), trichotillomania. The ensuing dialectical back-and-forth mimics some sort of guessing game or charade. If the person is aware of trichotillomania, the conversation normally looks like this:

Person: Oh dermatillomania? Is that like trichotillomania?

Me: Yes...

Before I have a chance to continue

Person: Derma! So, like something involving skin.

Me: Yes... *Me thinking that they’ve understood*

Person: *apparent confusion*

Me: It’s skin picking disorder. Derma = skin, tillo = pull/pick, mania = disorder.

Person: Oh, that makes sense.

Therefore, to avoid this type of awkwardly drawn-out communication, I might elect the term compulsive excoriation (skin picking) disorder, as its wording can be more easily parsed while still accurately conveying the disorder. The more familiar language caters to a larger audience. For this autoethnography, I have aimed at a universal intelligibility in a desire to reach

a diversity of groups, such as physical and mental health professionals, social workers, students, professors, individuals living with this disorder, and members of the broader public. Additionally, I have desired to stay true to how I speak about my disorder informally, e.g., my use of the term dermatillomania, which appears in personal poems I have written, cited later in this paper.

Ultimately, each person living with this disorder is at liberty to decide which term they prefer to use. The above are simply reflections based on personal experience that I share in order to raise awareness of how terms can be paramount to the comprehension of this disorder.

INTRODUCTION: CONTEXTUALIZNG CSPD

Mental health conditions have been on the rise around the world. Statistically, one in five Canadians will experience a mental health issue (Lee & Jung, 2018). Social norms and societal pressures play an important role in today's mental health crisis. The social context in which we live, here, in the Western world, creates and sustains an overwhelming amount of pressure to succeed both academically and vocationally. With these external stressors and the expectation of achievement, there is a higher likelihood for individuals to "choke under pressure," leading to failure, no matter whether an individual believes in their own success or not (Baumeister et al., 1985). However much this exaction might influence success, it also invariably contributes to mental distress. For example, there has been evidence that "although individuals with [C]SPD [compulsive skin picking disorder] did not have significant impairments in academic performance as determined by overall GPA, they had significantly worse depressive symptoms (PHQ-9 scores), significantly higher levels of perceived stress, considered themselves significantly less attractive than people without [C]SPD and reported significantly more days of poor physical health in the last 30 days compared to those without [C]SPD" (Odlaug et al., 2013, p. 169). This type of

adversity overlaps with the other societal pressures people living with CSPD experience, such as beauty standards.

Societal norms and expectations have evolved over time. For women, they have only continued to intensify with the innovation of social media. Given the possibility of being photographed and having those images posted across several different media platforms to remain for eternity, the pressure is ever higher to look one's best (McCabe et al., 2020). However, the questions oftentimes posed are "What does it mean to look your best self? What makes you beautiful?" Beauty is subjective and relies heavily on social comparison.

In the past, marketing found on television and in magazines was of greatest concern, however now unrealistic images of beauty are everywhere. Retouching technology is more accessible to everyone with apps like Facetune, which allows individuals to completely change their shape and skin tone, cover blemishes, adjust lighting and more (Tait, 2018). In Tait's article one teenager referred to this phenomenon as "the digital version of plastic surgery" (2018). While not everyone uses these apps, Instagram influencers with a high volume of followers certainly modify the way they look to fit the ideal beauty standard, which in turn upholds an unrealistic image contributing to poor self-esteem, body dysmorphia and social anxiety (Jin et al., 2018). For individuals living with CSPD, this beauty standard creates further insecurities around visible blemishes and redoubles the pressure on them to hide their marks with makeup and/or long sleeves/long pants. These response tactics only escalate feelings of shame, embarrassment, and low self-esteem, all of which will be further explored throughout this journey to authenticity.

There is a prodigious text developed by the American Psychological Association called the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5* (DSM-5) that is known as the "bible" of mental illnesses. The first version was published post World War II in

1952 and consisted of 130 pages. Flashforward to 2013, the year the latest version was released, and the page count now stands at 992 (Rachman, 2015). In Canada, if a mental illness is not in the “bible,” it does not exist. In other words, a doctor, psychologist or psychiatrist will not make a diagnosis unless it is in the DSM-5. For example, someone experiencing “professional burnout” will often not receive that particular diagnostic designation because it is not part of the DSM-5; instead, they will regularly receive the diagnosis called adjustment disorder (Chirico, 2015). The reason behind this substitution lies in the patient’s need of an “official” diagnosis for paperwork, for purposes such as reimbursements by their insurance company for stress-leave or university accommodations. To illustrate, when I applied for accommodations with my university, I needed to provide a mental health certificate, which includes a standard line asking for “Diagnosis: _____ If applicable, specify: DSM-V (Axis I and/or II)_____.” Finally, a DSM-5 entry lends a certain legitimacy to a mental illness attributable to its research-based, specific and well-defined criteria.

The DSM-5 is divided into 20 chapters, each of which focuses on varying types of mental health disorders (Regier et al., 2013). One category comprises *obsessive-compulsive and related disorders*. This section has incorporated a new chapter adding further categorical diagnoses, viz., *excoriation (skin picking) disorder*, which is closely related to *trichotillomania (hair pulling disorder)*, an entry contained previously in the DSM-4 (1994) (Regier et al., 2013). Although its official diagnostic entry may be new to the DSM-5 (2013), CSPD has always been prevalent; originally viewed as an impulse issue, it failed to receive an appropriate title or categorization (Regier et al., 2013).

Impulse control disorders (ICD) are frequently easily confused with obsessive-compulsive and related disorders (OCRD) on account of the similarity between “impulses” (see ICD) and

“urges” (see OCD) (Stein et al., 2016). To make this important distinction: “...the mental phenomena in OCD [obsessive-compulsive disorders] are experienced as intrusive, unwanted, and commonly associated with anxiety or distress, and that behaviours undertaken in response to obsessions (i.e., compulsions) are not experienced as pleasurable, although they may result in temporary relief from anxiety or distress” (Stein et al., 2016, p. 666). When researchers and professionals were considering the induction of compulsive excoriation (skin picking) disorder, there was lengthy debate on whether it should be categorized with impulse disorders, anxiety disorders, obsessive-compulsive and related disorders, or if a new category should be created to encompass all body-focused repetitive behaviours (BFRBs) (Solley & Turner, 2018; Stein et al., 2010). In other words, rather than trying to fit this disorder into an existing box, the DSM-5 task force opted to create this new category: "Body-focused repetitive behaviors (BFRBs)...a group of disorders that include skin picking, nail biting, hair pulling, and other various repetitive action behaviors. They can vary from common habits that many individuals engage in, all the way to behavioral disorders that can be detrimental to daily living" (Skurya et al., 2020, p. 1). The rationale for creating this separate grouping derives from the clear distinctions BFRBs demonstrate juxtaposed with other OCD, such as, “they are rarely preceded by cognitive phenomena such as intrusive thoughts, obsessions, or preoccupations, but instead may be preceded by sensory experiences” (Stein et al., 2016, p. 670).

The following section will further discuss and review the literature that exists on CSPD. Subsequently, the research question will be presented along with its objectives.

LITERATURE REVIEW

Compulsive excoriation (skin picking) disorder (CSPD) affects five percent of the general population; despite this fact, few professionals are aware of what it is and how to treat it (Golomb, Franklin, et al., 2016). This disorder is more commonly diagnosed in women, but when men are affected it manifests similarly (Hallion et al., 2017).

There are several definitions of CSPD. Mintsoulis (2015) describes it best as “a mental health disorder characterized by excessive picking of one’s skin resulting in clinically significant functional impairment.” Most research on this disorder derives from medical, psychiatric, and dermatological journals. It generally tends toward scientific and study-based articles that either attempt to explain the severity of the disorder or outline possible treatments.

Employing a scientific dermatologic perspective, authors Jones, Keuthen and Greenberg (2018) evaluate the different types of pulling or picking associated with body-focused repetitive behaviours such as trichotillomania and compulsive excoriation (skin picking) disorder. The original conception of CSPD hinged on the notion of “automatic” picking, which referred to habit-like behaviour or subconscious behaviour. However, these authors believe there are two additional factors, “intention” and “emotion” (Jones et al., 2018). Yet, once again, this type of research is not centered on the individual but rather on figuring out an etiology and explanation for this disorder, thus neglecting to take into account the diversity of people or the dimensions of *intersectionality* (Simien, 2007). The concept of intersectionality “was introduced in the late 1980s as a heuristic term to focus attention on the vexed dynamics of difference and the solidarities of sameness in the context of antidiscrimination and social movement politics. It exposed how single-axis thinking undermines legal thinking, disciplinary knowledge production, and struggles for social justice” (Cho et al., 2013). The term was coined by a Black feminist named Kimberlé Crenshaw to explain

how a multitude of identities cannot be separated but must be examined as a united entity. Examples of identities include skin colour, gender, class and (dis)ability (Simien, 2007). Therefore, the aforementioned study on CSPD failed to examine social context, wherein the level of oppression or adversity an individual faces may potentially have an impact on the severity of their skin picking or even their resilience with regard to the disorder.

Research adopting a psychiatric perspective aims to address specific triggers that may occur in the brain. For example, Schienle and Wabnegger (2018) conducted a study examining whether or not visuals of skin irregularities are triggers for people with CSPD. The imagery not only incited the compulsion but evoked feelings of disgust. The study also revealed that the amygdala in the brains of the subjects became activated. This result fascinates as “the amygdala is the linchpin of human emotion. A deep structure of the brain...[t]he vital responsibility of the amygdala is to receive information from the environment, evaluate its emotional significance, and organize a fitting response” (Miller MC, 2005, n.p). With these findings, the conclusion of this study demonstrates that people with skin picking disorder show elevated levels of disgust, which could correlate with the disorder.

Another similar study was conducted by a psychiatric journal but implemented cognitive behavioural therapy (CBT) techniques (Schuck et al., 2012). CBT is defined as “a therapeutic approach that focuses on identifying thoughts, feelings and behaviours that are problematic and teaches individuals how to change these elements to lead to reduced stress and more productive functioning” (Golomb, Franklin, et al., 2016, p. 9). The main technique discussed is the approach-avoidance task, which uses pictures of skin irregularities, healthy skin and a control stimulus to determine triggers and severity. When participants with CSPD were shown pictures of skin irregularities, they would hesitate to pull the image towards them and, ultimately, push away the

image. Whereas the control group without CSPD did not exhibit any variance. The participants deemed to have CSPD meeting the criteria of the research, “received four 45-min treatment sessions of cognitive-behaviour therapy, administered over a period of five weeks.... The treatment sessions were conducted according to a treatment manual.... After each treatment session, homework assignments were given (e.g., registration of the time spent skin picking, completion of cognitive therapy registration forms, and regulation of skin picking)” (Schuck et al., 2012, p. 686). The results determined that sight and feel (touch) are triggers for picking behaviour (Schuck et al., 2012). They further predicted that CBT would be more successful for those individuals whose skin picking behaviour was more sight inclined (the greater focus of this research) than for those who were more tactile inclined. There seems to be a connection between this study and the previous findings of Jones, Keuthen and Greenberg (2018), which investigated “automatic” versus “conscious” picking. Potential correlations were suggested between “automatic” and tactile inclined picking as well as “conscious” and sight-inclined picking (Jones et al., 2018; Schuck et al., 2012). However, supplemental research is needed to explore these correlations.

Scant research speaks specifically to the individual experiences of those living with compulsive excoriation (skin picking) disorder; instead, the majority predominantly co-opts quantitative data obtained using surveys. For instance, Hayes et al. (2009) is one of many studies (of those that exist) to focus on uncovering the prevalence of skin picking, even prior to the disorder’s official—quantitatively based—diagnosis in the DSM-5. The criteria were “...any manipulation of regular or irregular skin that resulted in damage would be considered skin picking in this research” (Hayes et al., 2009, p. 315). After tracking 354 subjects, the researchers continued the study to look for severity of symptoms based on several distinct Likert scale questionnaires

evaluating the social impacts of CSPD along with other possible comorbidities. Among the various standardized tests taken by participants, the Skin Picking Impact Scale (SPIS) (see appendix A) was salient (Hayes et al., 2009; Keuthen et al., 2001). A key result determined 76% of skin pickers were female. In addition, subjects who scored higher on other standardized tests (ex: depression, anxiety) had more clinically significant skin picking (Hayes et al., 2009). While these types of research studies are valuable, they overgeneralize and skirt the importance of understanding individual experiences. Case in point, based on the criteria quoted above, how can a determination be made about whether skin picking was impactful for the individuals' daily functioning and, if so, in which ways it was impactful? As for the subjects' own interpretations of the results, do they feel they pick their skin because they are anxious, or are they anxious because they pick their skin? Individual experiences can provide a different perspective with unique insight that can be useful to those within the CSPD community itself and amongst researchers.

Many researchers have found comorbidities² between skin picking disorders and other mental illnesses such as depression, anxiety, post-traumatic stress disorder, obsessive-compulsive disorder, trichotillomania and more (Hayes et al., 2009; Odlaug & Grant, 2008). Due to the fact that research on this subject is still in its early stages, by and large findings are based on similar disorders such as obsessive-compulsive disorder (OCD) and trichotillomania (Mintsoulis, 2015). The medications that have been successful for OCD are also used for CSPD and have evinced some degree of effectiveness. These are called selective serotonin reuptake inhibitors (SSRIs) (Mintsoulis, 2015). Additionally, an amino acid supplement has been explored as a

² “The term comorbidity refers to the co-occurrence of distinct disorders, each presumably with its own etiology, pathology, and treatment implications” (Widiger & Samuel, 2005, p. 495).

therapeutic medicine for body-focused repetitive behaviours, such as CSPD, called N-acetylcysteine (NAC) (Silva-Netto et al., 2014), which likewise has proved effective in studies. In an article written by Grant et al. (2016), the authors explain the results of a clinical trial using N-acetylcysteine (NAC) and a placebo in the treatment of compulsive picking disorder. Severity of the disorder was measured first to ensure the study's accuracy. Results showed improvement in reducing symptoms of skin picking disorders and other compulsive behaviours (Grant et al., 2016).

While these two pharmacological options are being used to treat CSPD, no drug has received official approval for treatment of the disorder. Other (non-medication) treatment alternatives include different types of therapy, such as Acceptance and Commitment Therapy (ACT), Habit Reversal Training (HRT), Dialectal Behavioural Therapy (DBT), and Cognitive Behavioural Therapy (CBT). In one study, patients who received HRT decreased their urge to pick by 77% within just one month of therapy versus those who did not enter into treatment (Mintsoulis, 2015).

While obsessive-compulsive disorder is not the same as CSPD, the two belong to the same family of obsessive-compulsive and related disorders as they share a commonality of obsessions, compulsions, and rituals. Moreover, due to the lack of research on CSPD, at times OCD studies are tapped for their prospective application to skin picking or to determine whether an analogous trial can be performed for CSPD. There is an article that focuses on how individuals with obsessive-compulsive disorder can be influenced by their relationships (Abramowitz, 2017). Its methodology piqued my interest as it paralleled the HRT³ that is typically used for CSPD. In particular, the study evaluated couples in long-term committed relationships where one partner

³ To be delineated further in the section "Health Professionals."

was experiencing OCD symptoms. Emphasis was placed on how the social context of an individual living with OCD can significantly impact their condition negatively or positively. The social context evaluated in this study amounted to *partner-assisted* treatment via Exposure and Response Prevention (ERP). The objective of this type of therapy revolves around attenuating the accommodating behaviours partners might implement with good intentions but that can have negative impacts on their loved ones who are experiencing OCD.

To clarify, ERP emphasizes allowing an individual with OCD to be exposed to stimuli that are distressing and to develop increasing tolerance in the response period. In other words, should a person have an obsessional thought, rather than following it with a compulsive ritual to calm their anxiety, they learn to tolerate it, thereby reducing their overall fear. Quieting the initial anxiety seems logical, but in actuality this reinforces the validity of the irrational obsessional thought, thus creating a pattern of distress. Habituated to the former, incognizant, mindset, partners often wish to avoid seeing their loved ones in distress and will attempt *symptom accommodation* to soothe the obsessional thoughts by performing rituals for them, which feeds into irrational fear and reinforces the obsession.

While there is not an abundance of research on partner-assisted ERP, the research that does exist has small sample sizes and the results are mixed re its effectiveness. However, in this particular study, a 16-session couple-based ERP program was developed that included four main components: “(a) psychoeducation; (b) partner-assisted ERP; (c) couple-based interventions focused on reducing OCD-specific accommodation behaviour and increasing alternative strategies for couple engagement; and (d) general couple therapy focused on stressful aspects of the relationship not directly related to OCD” (Abramowitz et al., 2013 in Abramowitz, 2017, p.7). A case study was presented that demonstrated proof this program was successful.

An article written by Gallinat, et al. (2019) outlines an internet-based self-help pilot study called SaveMySkin aimed at helping individuals with skin picking. The pilot study consisted of an online 12-week program that was rooted in cognitive behavioural therapy. The internet program featured resources, exercises, monitoring systems, and online counseling via chat. The empirical goal was to evaluate whether skin picking improved, if users were satisfied, and how willing subjects were to participate. The results were favourable, as most participants did show improvement in reducing their skin picking symptoms. However, the author of the study cautions that, while the evidence is promising, more research is needed to confirm efficacy on a larger scale. While some therapies do appear to pave the way for hope, Odlaug and Grant (2008) note that many people with CSPD yet do not seek out treatment due to shame, embarrassment, or hopelessness.

In the handful of psychosocial articles that exist about CSPD, common themes explored include shame, embarrassment, and social avoidance. Several articles discuss the causal relationship between skin damage and feelings of mortification (Golomb, Franklin, et al., 2016; Snorrason et al., 2017; Solley & Turner, 2018; Weingarden & Renshaw, 2015). In comparison with other body-focused repetitive behaviours, "...individuals reporting skin picking reported greater levels of body image concern than those in other BFRB groups" (Solley & Turner, 2018, p. 15). Shame and embarrassment can be experienced to varying degrees; the initial act of "...pulling and picking, in addition to post-pulling and post-picking behaviors (e.g., chewing hair, biting roots, and chewing scabs), may generate symptom-based shame and secondary body shame. Thus, a cycle may develop, in which BFRBs generate shame, which in turn triggers additional engagement in BFRBs" (Weingarden & Renshaw, 2015, p. 80).

Only recently, since 2013, have such observations become more widely discussed by medical professionals. Ergo, there is a lack of research on the above subject matter, particularly

from a biopsychosocial perspective.⁴ It is important to consider that “we are each bundles of genes, reacting and changing in response to the environment, and the sooner that we accept this and move beyond the tired nature vs. nurture debate into a fully integrated biopsychosocial understanding of people, the sooner we can move towards truth” (Barlow, 2019, p. 69).

RESEARCH QUESTION AND OBJECTIVES

My research question is as follows: *How can a deeper understanding of compulsive excoriation (skin picking) disorder be achieved through the exploration of a lived experience?* The objectives in pursuance of this question are 1) to raise awareness, garner knowledge and disprove misconceptions about compulsive excoriation (skin picking) disorder for the purposes of providing strategies on how to coexist with compulsive excoriation (skin picking) disorder as well as guidance for the health professional community, the general public, and families on ways they can support an individual living with compulsive excoriation (skin picking) disorder; 2) to embark on an emancipatory journey to authenticity through the process of writing an autoethnography; 3) to critically analyze the sociopolitical dynamics inherent in the experience of living with a mental illness in modern-day Western society.

METHODOLOGY: CHOOSING AUTOETHNOGRAPHY

In answer to my research question, I decided to produce an autoethnography. This type of methodology is qualitative and uses a combination of autobiography and ethnography techniques to lend a new subjective perspective to the investigative process. As a result, the research can

⁴ It was challenging to gain a sociological perspective while conducting this literature review. The keywords I used to search were “Skin Picking Disorder” or “Excoriation Disorder” or “Dermatillomania” in the Social Services Abstract, Google Scholar and uOttawa Library academic search engines.

venture beyond the numerical data of quantitative studies. Autoethnography seeks to combine elements of an autobiography and ethnography in a harmonious way so as to unveil the value of lived experiences, which offers meaningful and pertinent information. As Ellis, Adams and Bochner state, “Autoethnographers must not only use their methodological tools and research literature to analyze experience, but also must consider ways others may experience similar epiphanies; they must use personal experience to illustrate facets of cultural experience, and, in so doing, make characteristics of a culture familiar for insiders and outsiders.” (C. Ellis et al., 2011, p. 4).

This methodology is particularly relevant for the research objectives established. Guiding the reader through my chronological journey to authenticity will bring awareness to CSPD and provide important information about the disorder. Additionally, the process of recording my journey serves as a therapeutic and cathartic experience, which will allow me to learn how to better coexist with CSPD. Finally, as I reach my conclusion, I will be able to critically analyze the sociopolitical dynamics underlying life with mental illness in modern-day Western society by drawing on examples from my personal experience of living with CSPD.

HISTORY AND IMPORTANCE OF AUTOETHNOGRAPHY

This innovative research paradigm emerged in the 1980s as a result of a postmodern crisis of confidence in the legitimacy of social sciences (Ellis et al., 2011; Johnston, 2020). The downfall of the grand narratives cleared a path for exploring new ways of viewing research and knowledge production. Distinctively meaningful narratives began to emerge that could interpret lived experience across a broader scope of social, cultural, and political contexts. At that time, accounts of lived experience actualized the higher purpose of resisting colonialism in research, which until

then had allowed a privileged minority to speak for other cultures, genders, generations and social classes, and thus control the production of knowledge (Ellis et al., 2011).

In the field of social work and in feminism, critical research leads to the creation of safe spaces and methodological devices for knowledge to be accrued *with* the input and contributions of women, marginalized peoples, minorities, and similarly othered populations. In this way, the research process ensures these groups a voice and invites subjective and intersubjective shared realities. This style of research is crucial. Otherwise, all too often—with or without good intention—experts tend to infer or project classifications and concepts or formulate causal hypotheses and draw problematic conclusions from their own positionality, ultimately, appointing themselves to speak on behalf of others.

Historically, ethnographers immerse themselves in a group, community, department, et al., to discern from within the whats, hows and whys of people's lives, choices, ritual celebrations, nomenclature, sources of meaning, and definitions of good and bad, etc. Ethnographic research aims to aggregate knowledge secured from observing communities and listening to individuals. The consummate purpose is to better understand the Other. While delving into a different frame of reference, ethnographers strive to open humanity up to alterity. They do so by highlighting the complexity of subjective experience, ever interwoven with intersecting networks of social, cultural and political signification (Ellis et al., 2011).

Autoethnographies tell personal first-hand accounts that can act as vessels to decant deeper meaning that "...traditional research tends to overlook" (Johnston, 2020, p. 138). Subjectivity in research is subject to debate within the research community. Some members are only willing to consider research based on an objective approach, as this guarantees scientific validity. Yet there are natural biases that exist in any branch of study or research; there is no such thing as a truly

neutral research topic. The requirement of a hypothesis guarantees prediction of how a given experiment or study might turn out, and, in turn, exerts collateral influence on either the results or the formulation of the discussion. Other critical and humanist researchers argue that an understanding of individual and social realities can only be achieved through the sharing and analysis of lived experience. Autoethnography acknowledges and embraces subjectivity, even shining a spotlight on it, with recognition that personal perception and partiality are a condition of our humanity, and cannot be avoided (Ellis et al., 2011).

Welcoming subjectivity allows space for the autoethnographic researcher to express herself authentically and emotionally while writing in a personalized style that best conveys her message. This opens the door to the use of different mediums of creativity such as poetry and photography.

EMBRACING SUBJECTIVITY THROUGH CREATIVITY

In this autoethnography, works of both poetry and creative photography are included to augment the vulnerability, depth, and interpretation of story construction. The art of “poetry has a distinctive value compared with other cultural objects and experiences, not least because of its ability to connect people’s cognitive and affective responses, mind and body, experiences and memories” (Simecek & Rumbold, 2016, p. 310). Poetry explores a divergent avenue of connection to the reader. Further, the demonstration and delivery of the poem(s) can be enhanced through varying modalities of expression, including spoken word or physical movement (Simecek & Rumbold, 2016).

Similarly, photography brings “together verbal and visual data in an integrative manner [which] offers the potential for a more encompassing understanding of experience (Buckle & Dwyer, 2019, p. 1). Both methods of this pluralistic approach contribute not only to enhancing and enriching the comprehension of the reader, but also to evoking the reader’s reflexivity and sense

of curiosity to explicate further and absorb more. In addition, autoethnographic research is reader-friendly and therefore more accessible to a broader audience than traditional academic papers (Buckle & Dwyer, 2019).

Autoethnographers' research often is challenged and accused of being self-indulgent (Johnston, 2020; Marshall, 2004; Stirling, 2020) due to its confessional nature. This brand of presumption is counterargued via the evidence of this methodology's successful conveyance within a larger systemic context. Juxtaposed with autobiography, autoethnographic narration epitomizes "the difference between monologue and dialogue, between closing down interpretation and staying open to other meanings, between having the last word and sharing the platform. Stories always have been used as a mode of explanation and inquiry in sociology" (Ellis & Bochner, 2006, p. 438).

While not all readers encountering this research will have a connection to compulsive excoriation (skin picking) disorder, they can still find value within this body of work that sheds light on larger systemic issues such as the mental health system, the stigma of mental illness, beauty standards, performance anxiety, and so forth.

My research project emerges from my 19 years of living with compulsive excoriation (skin picking) disorder. I have created a structure for my autoethnographic research, upheld by biographical writing and artistic creativity, to grasp, analyze and contextualize the in-depth experience of CSPD:

1. Transcribing my illness trajectory (my journey to living authentically):

I reconstructed my own experience of compulsive excoriation (skin picking) disorder in chronological order from the age of five to present day. At the outset, I organized my life into significant age milestones and time periods such as childhood, puberty/adolescence, university

experience, work experience, romantic relationships, treatment with health professionals, attendance of support groups, and the COVID-19 pandemic. I mapped out ideas on a board to systematize my thoughts and create a visual timeline to ensure that information recorded from memory would maintain as much accuracy and congruence as possible.

For each phase of life, I reflected on the following:

- a) how my compulsive excoriation (skin picking) disorder manifested itself, which emotions and thoughts were interrelated and how they were experienced
- b) how interactions impacted my experience within my primary environments, viz., at home, at school, at work, in the health field, with close friends; which facts, situations and events were sufficiently meaningful to warrant description; how my emotions and thoughts correlated with each milieu

After the initial visual draft was complete, I began to write, expanding on the nascent concepts and themes I had transcribed.

2. Poetry, Audio Recording and Creative Self-Portraits

I included poetry, an audio recording and creative photography as part of my autoethnography so as to layer ample exploration and insight into my depiction of the emotional toll CSPD can have on an individual. I believe these interactive elements to be crucial components of the storytelling.

I had written a poem previously, in 2019, that I wished to include in an effort to encapsulate the essence of the disorder. The poem appears paired with an audio version recorded contemporaneously with its composition. This poem inspired me to write another for the sake of contrast, and this second poetic work was followed by two more (those latter three all forged over the course of composing this autoethnography). Poetry has been an outlet for me in releasing

unpleasant feelings: as a medium, it is confidential, vulnerable, and intimate. Although allowing people access to these personal poems of mine is intimidating, I include them to send a strong message revealing the severity of this illness, in the hope that doing so leads to an empathetic and fuller understanding. Four poems are included in total, each offering a different perspective on CSPD. As I read through my first two contrasting poems, I discovered they would be even more impactful accompanied by photographic works. I made note of my inspiration and then had a friend assist me in writing words on my arms and capturing images of me. She also helped edit a second portrait incorporating verbal graphics. After these two photographs were finalized, I took time to reflect on them and realized that they could stand on their own as well. To honor that new objective, I included explanations for both pieces (see appendices B and C).

ANALYSIS

The process of analysis in an autoethnography is unique as it unfolds continuously throughout the writing experience. Writing is at the forefront of autoethnographic analysis as it is the “primary method of inquiry (Richardson, 2005), crafting stories that evoke the deeper contours of the author’s embodied, emotional, intellectual, and spiritual life in response to – and as commentary, interpretation, and critique of – the events, phenomena, and structures of human social contexts (Poulos, 2019)” (Poulos, 2021, p. 32).

In other words, the goal of undertaking a project such as this one centers on delving into deeper meanings, as both the participant and the observer of the research, which requires not only looking within but also taking a step back in an attempt to grasp the bigger picture. This multidimensional process occurs in concert throughout composition, as well as in isolated moments dedicated specifically to reflection. To begin this process, I analyzed a poem found in

the book *Project Dermatillomania: Written On Our Skin*, a compilation of various personal accounts (see analysis in appendix D) (Barton, 2017, pp. 84–85).

Throughout the writing process, discussions with peers, professors, colleagues, friends and family all helped nourish the reflexivity that allows for a more profound analysis (Poulos, 2021). Verbalizing ideas rather than transcribing them is another mode of expression that creates opportunities for greater synergy. Receiving feedback, questions, remarks, and reactions from my social circle was inspiring and contributed to more meaningful analysis. My professor, who stood at the helm of supervising this autoethnography aided me in further deepening my analysis through an intensive week of critical reflection discussions, which took place twice a day. Immersing myself in this week of writing and reflecting enabled my autoethnography to achieve an otherwise unattainable breadth and perspicuity.

MY JOURNEY TO LIVING AUTHENTICALLY

INTRODUCTION TO THE JOURNEY

This autobiographical journey is organized chronologically to guide the reader through my childhood up until the present day. Inspired by Johnston’s (2020) autoethnography, “I [draw] on an ethnographic narrative form that is both poetic and story-like, and uses character development and plot description to illustrate points of tension and suffering that are difficult to put into words in everyday conversation or more traditional forms of academic writing.”

My story relies on intrapersonal and interpersonal memories recounting significant anecdotes to facilitate an understanding of the real-life experience of compulsive excoriation disorder, aka skin picking disorder (CSPD), from a bio-psycho-sociocultural perspective and through the interrelational lens of larger systemic issues. These viewpoints help highlight the

import and relevance of social expectations and norms. Furthermore, I will provide several examples of uncomfortable or anxiety-provoking social interactions regarding my CSPD. In fairness, I acknowledge that some of the exchanges depicted in this work were well-intentioned: my purpose in relating any unpleasant emotions I experienced is not to convey animosity on my part but rather to provide constructive feedback and education to those who were and continue to be unaware of the potential harm caused by their words.

One of the primary sources of suffering for those with CSPD arises from dealing with triggering comments. CSPD can cause physical skin damage and scarring; however, in my case, the quantity of emotional scars from social interactions easily surpasses that of physical scars. When delivered as a prescription or command, the word “stop” is a dagger to the heart, as CSPD is not a choice. It is not that simple. “Stop” serves as a reminder that I am not in control while simultaneously applying shame and guilt.

In my struggle with CSPD, picking offers a sense of relief or comfort, at least for the brief duration of the act. However, each picking episode is frequently followed by negative feelings, open sores and, at times, blood. Despite this damage, a sense of regret is absent because I feel the action *needed* to be taken, I *needed* to pick. That flake of skin could not stay, that bump had to be flattened, or that scab had to go – their textures all too satisfying to tear off, and all too distressing to leave untouched. While I used to hide and call this a “skin condition,” I now embark on a journey toward authenticity—I have compulsive excoriation (skin picking) disorder. Welcome aboard.

CHILDHOOD

My journey begins at the age of five when, one day, the back of my shirt lifted, just a little, and my parents noticed a mark on my lower back. The mark looked like a small pink scab. My father is a pediatrician, and my mother is a pediatric nurse, therefore both are knowledgeable about

all kinds of different medical conditions. My father has psoriasis, a “... chronic immune-mediated inflammatory skin disease with multiple phenotypically distinct subtypes eg plaque, flexural, guttate, pustular or erythrodermic” (Raharja et al., 2021, p. 170), which has a “major genetic component, with heritability estimated to be 60–90%” (Raharja et al., 2021, p. 170). Given this information, my parents believed that I had psoriasis just like my father. I would apply ointments, but the mark would continue to enlarge and worsen because I would not stop picking at it. My parents would tell me to stop and, as a child, I would try my best to obey, but I couldn’t help my behaviour. The spot did not itch, it simply needed to be picked. The texture of the bump needed to be flattened. The flake of skin had to detach for me to feel at peace.



At this point, the act of picking was present but was not considered a major problem from my parents’ perspective nor from my own. The location of the picking was not obvious, as it was on my lower back. A few months later a fresh mark appeared on one of my arms. This new location was extremely obvious, especially in the summer months, which invited t-shirts and shorter sleeves. From this point on, the phrases “stop that,” “don’t touch it!” and “stop it!” were hurled at me frequently. My arm would bleed because of the extent to which I picked my skin. The mark was no longer just a mark but had transformed into a lesion, an open wound. As it healed, the area would also grow in diameter; and once fairly or fully closed over, it was ready to be picked again. As winter came around, all my long-sleeved shirts became stretched out and stained because I would push up my sleeves in order to pick, and then use their fabric to absorb any flow after I started to bleed. In my embarrassment, I did not want people to see me bleeding or to ask me what

had happened. What would I tell them? I did this to myself. But why? Why would I do this to myself? My mind replied: I don't want to bleed, I don't want to hurt, and, yet I *must* pick, and I can't stop.

PUBERTY-ADOLESCENCE

As I began to develop acne, resisting the urge to pick my face became impossible. My parents would tell me to stop and that I would create scars or infection. I knew that, and I wanted to stop, but I could not. The compulsion in me would lash out and tell them “stop” back. This would cause tension between us, as we were mutually frustrated with one another. My brothers regularly teased me, as siblings do, about anything and everything. However, they did not make nearly as many comments about my skin picking as my parents; still, when they did, it stung. One of my brothers would badger me to stop, lambasting my actions as disgusting, gross or repulsive, while the other would comment that I resembled a heroin addict. Asking them to stop and communicating how their comments were not helpful only made my situation more amusing to them.

I noticed my skin picking worsen in grade 6, around the time I began puberty and, simultaneously, changed schools. Attending a different school was a major shift. I knew one person at my new school and traded an all-French educational environment for an English one with French Immersion. During classes, I noticed how, while focusing on the lessons, I would often pick my forehead—doing so seemed to help me concentrate. Sometimes, I felt I was in a trance, or another world, as I stared off into space picking at my skin. When I snapped out of this trance of *automatic picking*,⁵ I would sometimes be bleeding. In these moments, I would either use the inside of the

⁵ As previously explained, skin picking can function as a subconscious behaviour, akin to being on “auto-pilot” (Jones et al., 2018).

shirt sleeves to staunch the wounds or I would excuse myself to the bathroom so I could blot them with toilet paper. No teachers appeared to notice, nor did they ever comment. Classmates likewise showed no signs of perceiving my picking, but they did notice the gashes on my face, and at times made fun of me for my skin imperfections. I felt extremely insecure about my skin, especially the blemishes and gashes on my face.

My mother did not allow me to wear makeup until high school, so camouflaging the wounds was out of the question. I had several friends who would complain about blemishes of their own that were hardly visible, which was frustrating to me: I knew similar blemishes on me would be much more obvious, red, and bleeding, due to my skin picking. In my mind, if their blemishes were deemed horrible, what did that mean for my blemishes, my wounds? My only conclusion was that others must view mine as disgusting.

One day, I had an appointment with my orthodontic hygienist. As I sat down, she exclaimed “Oh my goodness! What happened to your face? Were you in a car accident?” I remained quiet as my mother responded politely, “No she just has a skin condition.” The hygienist then replied, “Oh okay, I was worried, glad you’re okay.” Her reaction made my heart sink into my stomach with anxiety, embarrassment, and shame. I was anxious she would find out about my disorder. I was embarrassed and ashamed because of her reaction. Her exclamation offered me the harsh realization that however critically I judged my skin paled in comparison to others’ perceptions. As the inhabitant of my body, I have long been accustomed to seeing scars, bumps, bruises, and lesions. They appeared almost normal to me then, just as they do now. Until that moment, the severity of my injuries had not occurred to me. In other words, the hygienist had thought a picking mark was damage done by a car accident—but my CSPD was the “car accident.” This was

humiliating and incomprehensible to me. How could my skin damage look THAT bad? As a young teenager, yet unaware of my CSPD diagnosis, I could not fully comprehend this revelation.

Reflecting on this situation over 10 years later, I am aware of how my CSPD recast my well-intentioned and caring hygienist as an antagonist. In that instance, I was triggered, and the CSPD part of my brain set off alarm bells, as if the disorder were under attack or at risk of being discovered. I felt responsible for the “car accident” and reacted as though my hygienist were an investigator from an insurance company coming to interrogate me. Now, taking a step back, I recognize I was “not at fault” and neither was my hygienist. Although her verbal reaction might have been painful to hear, her intention clearly was to make sure I had not been hurt; she was being caring. I do not hold grudges against her or any others who have asked me about my picking marks in this way, because I trust their inquiries were pure and well-intentioned. I include such in-depth examples of the impact this type of exchange can have in an attempt to enlighten and educate people on how their words, tone and expressions might affect someone who suffers from CSPD, regardless of their intent or desire to help. This point will be elaborated further when CSPD awareness and interventions are introduced in subsequent chapters.

MOMENT OF DIAGNOSIS

At the age of 17, I was referred to a dermatologist by my family doctor because the lesion on my arm was getting worse. On the intake paperwork, I informed the dermatologist of my family history of psoriasis. As she examined my arm, she notified me that the lesion’s appearance was inconsistent with psoriasis but that its unusual presentation must have been owed to genetics, and also confirmed that the affected area did not resemble any other recognizable skin illness. She prescribed me medicated creams and took a swab of the lesion out of caution.

After my visit, I began doing my own research, googling: “I can’t stop picking,” “how to stop picking,” “skin picking,” and a Wikipedia page of “skin picking disorder” appeared. As I read on, I found I fit all of the criteria for the disorder. It made sense. I did not want to self-diagnose so I figured I would mention my picking at my follow-up visit with my dermatologist. Two weeks after my initial consultation, I had my appointment. The doctor remained unsure of her psoriasis diagnosis. I started to explain how I had borne this mark on my arm for years, and that it did not go away because I would not stop picking at it. I shared that the abraded area became even more acute when I was anxious. Given this new information, she immediately diagnosed me with compulsive excoriation disorder. I had no idea what that was. I did not know it was identical to the “skin picking disorder” I had googled. When I asked, she explained, and added, “*there is no cream in the world that I could give you that will help your skin, what you need is a psychiatrist.*” In retrospect, that sentence seems extremely harsh. However, in the moment, I felt relief. I felt heard. I felt seen. I spoke to my mother about it afterward and explained to her that I would need to see a psychiatrist.

In Ottawa, psychiatrists are in high demand and often have extremely long waitlists. Fortunately, I have the privilege of two parents in the medical field who were able to make a few calls to get me in to see a psychiatrist within a couple of weeks.⁶ When I asked my father for assistance finding a psychiatrist, he respected my discretion and agreed without pressing me to reveal my reason for consulting. As a pediatrician he understood the gravity of confidentiality, and therefore could grasp how his teenage daughter might not want to disclose her personal mental

⁶ I am aware privilege plays a large role in my ease with accessibility to mental health services. I will expand on this further in my discussion of the challenges that arise when seeking mental health services is less accessible, as is true in many circumstances.

health struggles to him. I am thankful that he respected my privacy as I was not ready to talk about my CSPD with him at that time (CSPD not being a subject we normally discussed with one another). I had confided in my mother, since our relationship was close, and I wanted her to understand why I could not simply comply every time she told me to stop.

Finally, I could explain and corroborate that picking was not a bad habit but an actual disorder. She had not heard of compulsive excoriation disorder but was empathetic when I shared. Nonetheless, acquiring this new information did not deter her from saying “stop.” Without the burden of personal experience, the intensity of the compulsion to pick is difficult to fully comprehend. Therefore, I can appreciate the good intentions behind my mother’s directives, as she did not want me to cause damage to my skin. However, contrary to her aims, these exhortations would further trigger me and provoke my picking, which I then continued in shame and in hiding. My mother was the only one who knew about the disorder since, as a rule, I kept my diagnosis to myself. I did not think people would understand and I did not want to have to explain myself to others.

THE UNIVERSITY EXPERIENCE

Before delving into this section on my experience at university, I must address how compulsive excoriation (skin picking) disorder often has comorbidities with other mood disorders. In what follows, I discuss different diagnoses I have received throughout my life. I initially debated whether I wanted to share this part of myself in my autoethnography for two reasons: 1) I do not want to be viewed differently in my career as a social worker; 2) I do not want to reinforce the MYTH that skin picking, and anxiety are synonymous or automatically linked.

Ultimately, this writing process represents an opportunity to learn self-acceptance and a journey of self-transformation to achieve authentic self-representation through releasing the stigma

of mental illness. As a university student completing my Master of Social Work, I wish to be a role model of how mental illness does not signify unintelligence, incapability, or weakness. A mental illness is not an identity. People live with mental illnesses just as they do other types of illnesses. While there are challenges, there are also ways to cope. In sharing my journey, I aim to reduce the stigma of mental illness and help others who may be experiencing difficulties with their mental health.

Additionally, this thesis renders a platform for explaining how anxiety does not cause skin picking, though it can be one of many triggers. Compulsive excoriation (skin picking) disorder and generalized anxiety disorder (GAD) are two independent diagnoses, each with its own distinct criteria in the DSM-5. Keeping this in mind, I utilize this section to explore my university experience and reveal the challenges faced therein.

School has always been challenging for me. In 2016, I began my Bachelor of Social Work at the University of Ottawa. The summer prior to starting the program, I decided to get a *Psychoeducational Assessment* administered by a neuropsychologist to evaluate whether I had attention deficit hyperactivity disorder (ADHD) or any other learning disabilities. This test revealed that I do exhibit many symptoms of ADHD, though not enough for a formal diagnosis. However, I was diagnosed with a working memory learning disability. Shortly after being evaluated, I began seeing a psychiatrist named Dr. Richards,⁷ whom my parents credited with sufficient understanding of ADHD (as they continued to believe those symptoms were prominent).

Based on our sessions, Dr. Richards agreed with my psychoeducational assessment that the diagnosis was unclear. Yet, he added that the ambiguity might be expected given my symptoms of

⁷ Dr. Richards is a pseudonym to respect the confidentiality of the psychiatrist's identity.

anxiety. In 2017, I was diagnosed with generalized anxiety disorder (GAD). As I was preparing for university, my anxiety and inattention were the focus of my treatment. His approach was weighted toward pharmaceuticals rather than psychotherapy. Sessions were irregular and sporadic, and largely based on trial and error for medications. Also, I would make appointments when I felt overwhelmed by school, and Dr. Richards would provide me with documentation for extensions for university deadlines.

While I experienced a degree of benefit with some of these medications, such as mood stabilization re my anxiety, I felt I needed more. I needed coping strategies and psychotherapy to accompany the medication in order to help me with processing my thoughts and emotions. From my standpoint, psychotherapy plays a large role in what supports an individual along their mental health journey to recovery. After about 12 sessions discussing various medication options, switching prescriptions, and arranging for medical notes, I decided to stop treatment.

My skin picking had not been discussed, as I did not have a good *therapeutic alliance*⁸ with Dr. Richards. I had not felt comfortable opening up about that part of myself. Later in 2017, I consulted with a new psychiatrist by the name of Dr. Harper⁹ to address my CSPD (these sessions will be discussed further in the chapter on health professionals).

School has long been, and continues to be, one of the biggest triggers for my anxiety. I have always wanted to perform to the best of my ability. In other words, anything below an 80% has qualified as disappointing. In my past, not only did I put this pressure on myself, but I also surrounded myself with peers with similarly high academic performance, to whom I would always

⁸Therapeutic alliance refers to "...the collaborative relationship between patient and therapist in the common fight to overcome the patient's suffering and self-destructive behavior. According to the author, the therapeutic alliance consists of three essential elements: agreement on the goals of the treatment, agreement on the tasks, and the development of a personal bond made up of reciprocal positive feelings" (Ardito & Rabellino, 2011, p. 2).

⁹Dr. Harper is a pseudonym to respect the confidentiality of the psychiatrist's identity.

compare myself. While for some, getting an 80% is a simple feat, requiring little to no studying, for me—with my anxiety, symptoms of ADHD, and learning disability—it took all my effort. Nothing ever came easy to me. Often, I would procrastinate due to my difficulties, which in turn would lead to an increase in skin picking. But school was not always about stress; sometimes, instead, boredom was my trigger. Attending a class on a subject I found uninteresting or difficult, or one where I exhausted exceptional effort in order to concentrate, were alternate instances that caused an upsurge in my picking.

A pattern was evident. During the school year, my skin was crowded with blemishes, lesions, and open wounds. Whereas, in the summer, my skin appeared much clearer—not perfect, but distinctly better. This pattern has held true throughout other stressful periods in my life, such as my years of interactions with health professionals, as detailed in the following section.

HEALTH PROFESSIONALS

Although this section overlaps with my time at university, my experiences with health professionals in my late-teens and early adulthood merit separate emphasis.

In 2019, during my third academic year, my excoriation disorder was exacerbated by stress, and school became highly stressful. I discovered a program at the university offering free mental health services and began psychotherapy in the hope it would assist me in managing my anxiety and picking. I was hesitant to discuss my skin picking, as the majority of professionals lack awareness of the disorder. However, to my surprise, my therapist, Shelley,¹⁰ shared with me her own diagnosis of trichotillomania (a kindred body-focused repetitive behaviour), and thus was cognizant of my disorder. She informed me that skin picking disorder is more addictive than

¹⁰ Shelley is a pseudonym to respect the confidentiality of the psychotherapist's identity.

cocaine, and I was oddly relieved. While irrefutably a daunting statement, it was also a validating one: it meant the inability to stop picking my skin was not my fault and stopping was not as simple as so many people had asserted.

At this point my anxiety was impairing my daily functioning more than my CSPD, so greater focus and emphasis were placed on anxiety management during our sessions. In other words, my anxiety was creating more barriers for me in everyday activities, e.g., completing schoolwork, taking notes in class, and generally unwinding or accessing a sense of calm.

The single strategy we did pursue in relation to my picking was distress tolerance, "...[which] is defined as the capacity to experience and withstand negative psychological states" (Simons & Gaher, 2005, p. 83). I still try to implement this strategy as much as possible. The core concept involves training the body to tolerate the discomfort of not picking by first building resistance around other more minorly disagreeable sensations, such as an itch. For example, I would ignore an itch for 30 seconds before allowing myself to scratch it. Eventually, Shelley and I applied this technique to picking, and I have gradually increased the amount of time I can tolerate delaying the behaviour. This technique has potential for success, but would require more practice and exploration; and, since our primary concern has been my anxiety, I have not maintained an equal degree of checking in or accountability for my skin picking. Shelley and I have had a positive therapeutic alliance since our first session together and, to this day, she remains my trusted therapist. I could offer her direction on how I would like to orient our sessions, but I have struggled with stating my desire to stop picking. Part of me does not want to stop the behaviour, as I cannot imagine my life without it. Conversely and concurrently, I hate it.

To illustrate this complexity, I present two poems. I wrote the first in 2021 and the second in 2019. Encapsulating the love-hate relationship I have with this disorder with ordinary language is elusive; I have found poetry helps paint a clearer picture of the ambivalent contrast.

POETRY BY ALLISON GRODINSKY

MY DERMA FRIEND (2021)

Who has been there for me
Who has been consistent with me
Who is there to calm and soothe my anxiety
Who can help me concentrate intensely
Dermatillomania, my friend, always dependable
Debilitating yet makes me more capable
We have a love-hate relationship
I can't see my life without it
Bleeding out stress and negativity
While absorbing shame and serendipity
When there are ups and downs
Dermatillomania is always around
To pick me up off the ground
When the seasons begin to change
Things are feeling strange
Spots appear to help me think clearer
The sensation leads to the gratification
Making the gloomy sky turn into a new perspective
Beautiful leaves, breezy wind
Sitting here
With my best friend

Until the end



DERMATILLOMANIA (2019)

Dermatillomania is a special poem to me because it is the first time, I had ever written a poem on this topic. It was an outlet for me to release all the difficult emotions I was feeling at the time.

I decided to record myself reading the poem out loud because verbalization is another way that I cope; it was recorded full of emotion at the time it was written, originally without the intent of anyone ever hearing it. There are two lines that are italicized that are not included in the recording as they were added shortly after the recording was already made. I decided not to re-record to maintain the authenticity of the emotions felt during this moment. The recording can be accessed by scanning the QR code.

QR Code Instructions:

1. Open the camera or the QR reader application on your smartphone.
2. Point your camera at the QR code to scan the QR code.
3. A notification will pop-up on screen.
4. Click on the notification to open the website link.



My feet ache
As I lie awake
The skin is thin
Like paper ripped to shreds
I'm filled with constant dread
That I am ugly
That nobody could ever love me
Love these scars, truly love all of me
The blood drips down my arm
I didn't mean any harm
They tell me to stop
It makes me want to scratch or pop
Even more
More than I did before
I yell because I am unwell
I don't want to dwell
I know you mean well
Stopping is not an option
My brain is my corruption

I know it'll scar
I've come so far
This illness will never be erased
My body is its canvas that will never be replaced
No cream will help solve
My brain needs to evolve
The complexity of this rarity
It's taking over me
No matter how far
Far I've come
I will always leave a scar
With each scar, the stronger I hope to become
The scars mean healing
But I don't get that feeling
The damage is done
I'm ashamed of what I've become
Not even a filter will erase
The damage that I've done to my face
Dark spots cover my arms and forehead
I pick even before bed
Hidden beneath, nobody sees
My feet can be my worst enemy
I can't walk without pain
I am to blame for this pain I sustain
The lies about my "skin condition"
Gives dermatillomania more ammunition
This mental illness is no skin condition
No cream will fix this addiction
It's powerful
Undeniable
It's a part of me

It forever will be



HABIT REVERSAL THERAPY GONE WRONG

In 2017, I began sessions with a psychiatrist named Dr. Harper¹¹ to work on my skin picking. He did not inform me of which modality he would employ as a treatment approach; however, given what I know now, I recognize the therapy as Habit Reversal Training/Therapy (HRT). Regardless, the approach was ineffectual. During my literature review I learned more about HRT, and I believe its lack of success in my case can be traced to the psychiatrist's omission of certain fundamental steps.

¹¹ Dr. Harper is a pseudonym to respect the confidentiality of the psychiatrist's identity.

HRT has been the leading therapeutic treatment for BFRBs since its development in the 1970s (Golomb, Franklin, et al., 2016). Notably, it is the central methodology for addressing CSPD (Jafferany & Patel, 2019). It consists of several components: awareness training, competing response training, stimulus control, relaxation training and social support (Golomb, Franklin, et al., 2016; Skurya et al., 2020; Snorrason et al., 2017).

AWARENESS TRAINING

The initial step in HRT is awareness training, which involves “...helping the person focus on the circumstances during which pulling, or picking is most likely to occur. This enables individuals to become more aware of the likelihood that the behavior will occur, and therefore provides opportunities for employing therapeutic techniques designed to discourage performance of problem behaviors” (Golomb, Franklin, et al., 2016, p. 10). At this stage in my process, the psychiatrist did ask me to identify moments where I tend to pick. I felt shame and embarrassment at the prospect of divulging this information. Although hesitant, I trusted him enough to answer—while driving, watching television, concentrating on a task, or experiencing stress or anxiety. I further editorialized, basically all the time. What I did not know was that he had been observing my picking throughout the session. He proceeded to ask me how long I thought I had been picking. I responded that I was unsure as at times I do not notice. He remarked that in one hour I had picked for a maximum of five minutes. In this moment, I felt invalidated. In that controlled environment, of course, I was doing my absolute best not to pick in front of him. I oscillated between embarrassment, anger, irritation, and betrayal, as my emotional walls went back up. My heart racing, I had more anxiety leaving the office than when I had arrived. Despite the discomfort, I persevered and continued sessions because I wanted to give therapy a fair chance.

COMPETING RESPONSE TRAINING

Competing response training “teaches the individual to substitute another response for the pulling or picking behavior that is incompatible with the BFRB [body-focused repetitive behavior]” (Golomb, Franklin, et al., 2016, p. 9). Here, the approach began to take a turn in the wrong direction. At this point, the psychiatrist combined competing response training with stimulus control, which aims to “identify ways to reduce picking opportunities in the client’s environment and make picking more burdensome or less reinforcing” (Snorrason et al., 2017, p. 997). He suggested wearing gloves, long sleeves, band aids, and using any barrier possible. However, I had pursued all those suggestions already on my own and quite frankly did not find them helpful, given the strength of the compulsion. Gloves? I would take them off. Long sleeves? I would roll them up. Band aids? I would slide my fingers underneath to pick. His proposals felt almost patronizing. Finally, he introduced a competing response. I had mentioned how having wet skin reduced temptation to pick. Therefore, he recommended placing an ice cube on my picking area during urges. I made attempts, but the drive to pick outmatched walking to the freezer and grabbing an ice cube to melt on my arm. Moreover, the alternative offered nowhere near the same gratifying feeling. I tried, I truly did, but not picking increased my anxiety. As part of HRT, “three rules in the proper development of competing response include choosing a response that is incompatible with skin picking, feasible to complete anywhere with minimal effort, and not more noticeable than skin picking itself” (Jafferany & Patel, 2019, p. 341). Application of an ice cube is incompatible with skin picking; nevertheless, I could not feasibly complete the action anywhere with minimal effort, particularly in public settings. As this strategy proved challenging for me to execute individually, the psychiatrist introduced social support.

SOCIAL SUPPORT

Social support might be the most crucial and, simultaneously, the most daunting step of HRT. The social aspect is formidable, since people with CSPD, myself included, tend to feel shame, embarrassment and guilt about their picking. Social support involves having a friend, loved one or family member, help redirect the person who is picking toward their competing response and provide positive feedback when the individual succeeds in redirection on their own (Golomb, Franklin, et al., 2016; Jafferany & Patel, 2019; Skurya et al., 2020; Snorrason et al., 2017).

Pointing out when someone is picking can be extremely triggering and aggravate the behaviour. For this step to go accordingly, the person positioned to support must be prepped and take part in therapeutic training with a psychiatrist to understand their role (Snorrason et al., 2017). Omission of this essential stipulation is what went wrong in my case. The psychiatrist proposed I ask my mother to hand me a cold water bottle to apply to targeted areas when she noticed me picking. My mom knew about my skin picking, but I hesitated because I found the behaviour embarrassing. Ultimately, I acquiesced. I explained the psychiatrist's suggestion to my mom, and she agreed. Instead of saying "stop" she would hand me a water bottle in silence. However, I was aware the water bottle meant "stop." To me, the gesture felt passive-aggressive, even though I had instructed her to do it and recognized it as well intentioned. The disorder informed me my mom was an antagonist; the compulsivity was so strong, one side of me became irritable enough in withdrawal to snap at her. Initially, I tried taking the water bottle and applying it, but eventually I refused. I could not do it. I would get angry because I *needed* to pick. My mother stopped giving me the water bottle per my request, with the shared realization the contract had made me more irritable.

RELAXATION TECHNIQUES

Relaxation techniques were never explored with my psychiatrist. Typically, relaxation helps the individual implement the competing response in a relaxed state and think more clearly. Some of the strategies specifically used for HRT include diaphragmatic breathing and progressive muscle relaxation exercises (Skurya et al., 2020; Snorrason et al., 2017).

IS HRT EFFECTIVE?

In my personal experience, HRT was not effective. In actuality, it created more distress than benefit. I have compiled what I believe to be key measures when implementing a therapeutic technique to help others and professionals have a more positive experience than I did. They are (a) to be transparent and explain the technique, along with its risks and advantages; (b) to implement the technique correctly, using research-based interventions and adjustments based on your client's needs—there is no one size that fits all; (c) to take the appropriate time needed and avoid rushing the steps into a single session: timing will vary for each unique individual. I encourage professionals to participate in thorough, ongoing training and maintain their certifications by continuing their education when relevant updates arise. Furthermore, additional qualitative, inductive, and participative research is needed to improve the efficacy of this type of therapy.

LEARNING ABOUT INTENTIONS

When I think back to my interactions with Dr. Harper, I mainly associate them with my negative HRT experience; nevertheless, he did equip me with one key strategy/realization that has genuinely helped me and that I continue to apply to this day. I am not one who typically responds well to metaphors or analogies, as I often find them to be patronizing. However, Dr. Harper used a metaphor that helped put into perspective the rationale behind why people ask questions the way

that they do. In order to better contextualize this understanding, I will explain how that pivotal session transpired.

The session took place in the summer of 2017. I was working as a full-time lifeguard and swimming instructor at the time. I arrived at this session in a choleric state. I was angry and frustrated that people could not seem to mind their own business. I let out my frustrations to Dr. Harper confiding that at least once a day a patron at the pool would make a remark about my skin and that I could not believe to what extent they pressed for more details (I speak more in depth about the types of comments the public made in my *work experience* section). Dr. Harper stopped me and rhetorically asked, “What would you do if you noticed I had a bandage on my arm? What would be your natural reaction?” He continued, humans are curious by nature, they want to know what happened. “But what is their right to this information?” I rejoined. Dr. Harper explained that it was my choice whether to answer, but to remember that when people ask, typically, they are not asking to be mean or out of bad intentions. They are asking because they care or because they are curious humans.

In that moment, I remained unsatisfied with his answer. Our weak therapeutic alliance no doubt compounded my malabsorption of the message. Yet, upon reflection, I realize how impactful this session was for me. I apply this measured way of thinking every time someone asks me about my skin. I mentally tell myself, “They are asking about the band-aid that is in full view because they are curious,” which seems to relieve some of my irritability. The confrontation is still challenging; the feelings of shame and embarrassment do not simply disappear, but at least this new mindset alleviates the built-up anger to a degree.

PHYSICAL DAMAGE: CSPD VERSUS SELF-HARM

Did you know self-harm and CSPD can co-exist, but that they are not the same?

A common misconception about CSPD is that it is a form of self-harm. This is an understandable confusion seeing as both are self-injurious behaviours; but there is a vital variable distinguishing CSPD from self-harm, and that is intent. To elucidate, “self-harm, [is] defined here as deliberate and voluntary physical self-injury that is not life-threatening and is without any conscious suicidal intent” (Laye-Gindhu & Schonert-Reichl, 2005, p. 447). Before self-harming occurs, thoughts of self-directed violence tend to precede the act. A study revealed some common reasons for self-harm: “‘I wanted to get relief from a terrible state of mind’ was selected by 70.9%, ‘I wanted to die’ by 59%, and ‘I wanted to punish myself’ by 43.6%” (Madge et al., 2008, p. 672).

In contrast, in the case of CSPD, the desire is not for pain, but to rid the skin of perceived imperfections. Based off my own experiences and those of individuals who openly share their stories in online BFRB support groups, picking may offer temporary relief but the accompanying negative feelings that occur afterward are far more significant. Personally, I do not engage in skin picking to punish myself—although I sometimes feel as though I am being punished when I am in pain subsequently. I have never picked my skin with the intention of soothing suicidal thoughts. As previously disclosed in the importance of naming CSPD, or compulsive excoriation disorder, the word *compulsive* warrants emphasis, since picking the skin is not deliberate nor voluntary. The physical self-injury is a result of the compulsion to pick the skin.

Compulsive inclinations are triggered directly by environmental cues via a process that is dissociated from the person’s desires, deliberation, and, in many cases, even conscious beliefs. As a result of repetition and reinforcement they become entrenched. It is their frequency, cue-

dependence, and dissociated nature, along with their disruptive impact on the normal psychological functioning of the person's deliberative and volitional processes, which set them apart and make them more difficult to control. (Henden, 2013, p. 374)

The intensity of the compulsion prompts individuals with CSPD to become entranced during picking episodes and inhibits cessation up until the point where they bleed or feel pain. In some instances, such a thrall undermines their ability to rationalize and evaluate the consequences of their actions, which can end in severe skin damage (Henden, 2013). In the following section, examples of how CSPD can cause physical damage are discussed.

PHYSICAL DAMAGE CAUSED BY CSPD

Compulsive excoriation (skin picking) disorder results in varying degrees of skin damage and can precipitate other issues such as pain, scars, hyperpigmentation, infections, nerve damage and, in severe cases, amputation. In my experience, I have had two incidents that required medical attention. I share these stories with reluctance as I am embarrassed by the extent to which I caused myself unintentional harm. Nonetheless, I choose to share because I wish to accurately depict CSPD in all its dimensions.

The first incident was a skin infection that developed on my arms. It began with a few pink raised bumps that mysteriously appeared and were the perfect picking candidates. Within a day, the spots covered the entirety of my arms, almost like chickenpox. They were itchy, sore, and bleeding. I was prescribed antibiotics from my doctor to treat the infection. Thankfully, despite my picking, the treatment worked effectively.

The second occasion that required medical attention was a plantar wart that I had on my foot. For most people, warts remain benign and are easily treated with over-the-counter products or with liquid nitrogen at the doctor's office. However, as someone with CSPD, this plantar wart

was a nightmare. I wanted to get rid of it so badly that, while rationally I knew picking would only make it worse, still I could not help myself. (Graphic details to follow, so squeamish readers are advised to skip to the **asterisk**.) I would scrape the wart with scissors, cut off excess pieces, and pick the wart until it bled. The wart would get bigger and continued to spread. *I had two smaller warts develop on my foot and one on my thumb as a result. I tried every possible over-the-counter product and repeat liquid nitrogen treatments, but nothing worked. I knew why. I knew that it would continue to get worse if I could not get rid of it. I was even contemplating looking into surgery. I did not want to risk infection or further spread this highly contagious virus.

Upon doing research, I found a new type of treatment called Swift Technology: “Swift is a new technology, developed in the UK, which has been licensed for the general treatment of skin lesions in Podiatry and Dermatology. Swift uses microwave energy which is delivered through a special probe applied to the skin to treat the affected tissue” (*Information for Patients - Swift*, 2019). This innovative treatment advertised a solution for afflictions (like mine) that did not respond to traditional treatments; and I really wanted to get rid of this picking target/wart.

I am privileged to have employment and insurance because this treatment cost \$250 per visit. The average number of visits required for treatment is three, plus an initial assessment fee of \$75. Thus, the total cost for me to remove the plantar wart amounted to \$825. When I share this story, people wonder why I spent so much money on such a “small” issue. In fact, to reiterate, this plantar wart was a big issue: as a major trigger for my CSPD, it would have posed an immense risk of further health complications had I not received treatment.

I am fortunate that these two occurrences have been my only and worst incidents of physical damage requiring medical attention. In one severe case of CSPD, a young woman nearly had to have her leg amputated: “In 2014, I was hospitalized from picking an area into an abscess

for the sixth time except on this visit I contracted the life-taking bacterium MRSA (methicillin-resistant staphylococcus aureus) and almost lost my right leg,” McKeaney said. “After having eight inches of my inner thigh removed, a vacuum placed inside that I wore like a purse 24/7, and put on a walker and into months of physical therapy, I could no longer silently suffer” (McKeaney, 2018, n.p).

While I do not believe CSPD requires a spotlight on physical damage to be valid, this manifestation emerges as an important nuance of the disorder, which is one of few mental illnesses presenting as both visible and invisible. This concept will be elaborated in the discussion section.

MY PERSONAL COPING STRATEGIES

Around the same time that I began seeing Dr. Harper, I decided to start getting my nails professionally manicured to see if that would mitigate my skin picking. I had worn fake nails (the dip powder variety) before but never with the intent to prevent skin picking. One day, while considering ways I might stop myself from picking, I thought of trying fake nails for that express purpose. Although wearing fake nails did not curtail the compulsive desire to pick, it did ameliorate the injuries to my skin. The fake tip is just thick enough to create a barrier so that when I do pick the nail does not break the skin. I have tried various barriers in the past but this one has been the most successful in helping to reduce the number and overall severity of picking marks.

Although discovering something that serves my recovery has been advantageous, its actualization is not without consequences. For one, on average, I spend about \$1066 yearly on manicures, which, as a student, is a sizable cost to work into my budget. Additionally, I have felt judgement from others, wondering why I “waste” my money on getting my nails done. In the face of censure, I feel shame over my expenditures, as well as for appearing vain and for my skin picking itself. Incidentally, with friends and family I share my opinion on how I believe nail salons

should be covered by insurance for those suffering with compulsive excoriation disorder for the sake of their mental and physical wellbeing. The dual toll CSPD can take should not be underestimated: persistent open lesions as well as scars left behind from the skin damage together can adversely affect mental health; and in severe cases, these lesions become infected creating serious physical health problems.

If fake nails can prevent self-injury, why then should they not be accepted as an appropriate and approved treatment covered by insurance? By the same token, I believe there also should be access and coverage to wigs, if desired, for those struggling with hair pulling disorder. Insurance companies predominantly consider physical suffering without accounting for social repercussions, which easily wreak negative consequences on an individual's overall wellbeing and quality of life.

As a second eventuality of electing to utilize fake nails, I have had to relinquish a hobby of mine. This concession might not seem major and, in the grand scheme of things, may not be. However, the choice between a pastime and treatment to prevent self-injurious behaviour is a poignant one—even when the decision seems obvious. Herein lies a sacrifice that I had to make. Due to my inability to stop picking at my skin, I now have had to give up something I used to greatly enjoy; awareness of that fact imparts a significant shock. This forfeiture may not continue forever but, for the time being, it is a constraint of my wellbeing. In a later chapter, I will discuss the effects of covid-19 nail salon closures on my CSPD and how I coped.

WORK EXPERIENCE

There are two significant work experiences I would like to share as they have been integral to my CSPD story. The first one concerns a part-time job I held for over five years as a lifeguard and swimming instructor. The second details my summer job with a child protection agency as a paid social work student intern.

I have had many work opportunities over the years, but the one I maintained the longest was a job as a lifeguard and swim instructor. In this position, my uniform for lifeguarding consisted of a sports bra, lifeguard piney, running shorts and a whistle. My uniform for teaching swimming lessons included a full-piece swimsuit, lifeguard piney and a whistle. Therefore, all my skin picking marks, lesions and scars were always visible during this employment.

Baring my skin picking marks, lesions and scars did not make me nervous every shift. However, having strangers from the general public approach and ask me about my arms on a regular basis eventually became exhausting. I would always reply that I had a skin condition. Unfortunately, some visitors would push further, and ask me “What kind?” and go on to make cream recommendations. I felt these interjections were out of place and, though potentially well-intentioned, they were embarrassing and draining to navigate. At times, these strangers would take guesses, rather than ask: they would speculate that I played rugby or fought a bear or even had been abused. I felt as though I was being mocked. What if I were being abused? I was appalled at the insensitivity and impropriety of these passers-by making such remarks in a public open space.

If reiterating “I have a skin condition” felt exhausting, I could only imagine the enervation I would endure upon revealing a skin picking disorder and how I would need to go into the rigamarole of an entire explanation—repeatedly subjecting myself to that type of toil seemed way more daunting.

The times I felt the most anxious as a lifeguard were the trainings where we had to practice any kind of rescue or first aid, since these meant my co-workers would crowd around me and be able to see my skin damage. Two expository examples come to mind. In the first scenario, I would act out a victim with a broken arm. In this situation, my co-worker would hover and could witness

the scars and open wounds on my arms, which made me uncomfortable and also anxious they might say something or be disgusted. My lesions would tend to look worse when in the pool as well. The second scenario entailed my portraying a spinal injury victim. The other lifeguard would need to strap me to the spinal board and, when they reached the feet straps, I was always on edge. The bottoms of my feet appear raw and torn to shreds when they are wet. I did not want them to see that. None of them ever said anything, so I am not sure whether they noticed and refrained from commenting or if they remained oblivious. I am just glad to have made it through the process.

From 2015 to 2018, whenever a co-worker would ask me about my arms, I would tell them that I had a skin condition. If they solicited specifics, I responded that it was eczema. Normally, that would be sufficient to halt their questions and we would move on to a different topic. Other times, they would ask me if my skin hurt, or they would say that it looked painful. I would shrug and say, “No it does not hurt, it looks worse than it is.” I did not like having to hide the truth, but I did not feel that either myself or others were ready to hear it at that time. From my standpoint, when someone asks me about my skin, they do not expect me to reply with “I have a mental health disorder called compulsive excoriation, or skin picking, disorder”; they probably anticipate an ailment related to an injury or a skin condition, not some “dramatic” mental illness. During this period, I did not want people to view me differently and, to the same extent, I did not want to put someone in the uncomfortable position of not knowing what to say—especially if they were not expecting something “so dramatic.” I use the word “dramatic” because I feel it pertains to the general stigma around mental illnesses: a mentality of “she just wants attention,” “she’s just being dramatic.”

For the first time, between 2019 and 2021, I began to open up a bit more about my CSPD. I felt as though I needed to be truer to myself and to be an active participant in my advocacy for

ending the stigma surrounding mental health and mental illnesses. I tried my hand at sharing my disorder with a few co-workers, whom I trusted. None of them had heard of the actual diagnosis, but a few confided they knew of individuals who perhaps were experiencing something similar. They were respectful and compassionate, which in turn made me feel better about having been honest with them.

SOCIAL WORK SUMMER STUDENT INTERN MAY 2018 – AUGUST 2018

In May 2018, I was extremely excited about starting my first job in line with my career goals in social work. I was the youngest paid intern hired—an intimidating fact—but I was ready and eager to learn. Unfortunately, the experience was not what I thought it would be. The work environment was highly stressful and, frankly, toxic. I would wake up filled with anxiety, not wanting to go into work. I had never felt that way before about any job. My skin picking grew worse. I had a meeting with my supervisor, for which I was already nervous, due to previous interactions she and I had shared that had been unpleasant. As I sat down, she blatantly asked me what the marks on my arms were and if I had been or was being abused. I was shocked. I was not sure whether she was joking or if she was being serious. Regardless, I laughed timorously and replied, “No, no, it’s just a skin condition.” I did not want to appear weak or to be seen differently in my career on account of my mental health disorder, so I refrained from divulging the truth. In addition, at that point in time, I had not yet shared that part of myself with many people. Despite my response, my supervisor was incredulous and persisted in asking me questions about my arms. I felt pressured, and so I figured what was the worst thing that could happen by telling her? After all, she was a social worker, who should practice nonjudgmental values and demonstrate empathy...

Allison: Well, I actually have skin picking disorder, so these are scars that just appear like bruises now due to hyperpigmentation.

Supervisor: Oh! It must be an anxious thing. I make it worse with my feedback?! Do I make you anxious? If you can't take feedback because it makes you too anxious let me know.

Allison: **Not once did I even mention anxiety? I am confused and annoyed that I am being questioned about my ability to receive feedback – my exact fear came true – I am seen differently now.** No, it actually has nothing to do with anxiety. I do it even when I am not anxious. I would like to receive feedback from you as it helps me improve.

Supervisor: Okay, well, if you are too anxious then I won't tell you anything.

Allison: **Did she hear me?** No, no, that is okay, I will let you know, but I do like receiving feedback. Thank you.

As I left her office, I felt belittled, embarrassed, ashamed, confused, frustrated, misunderstood, unworthy, stigmatized, discouraged, angry, sad, annoyed, and heartbroken. A flood of feelings and emotions rushed through me. One of my biggest fears was my career being called into question if anyone ever found out about my compulsive excoriation disorder or my generalized anxiety disorder. In this moment, I felt as though my dreams were being crushed.

Although, evidently, as I am now writing an entire auto-ethnography on these subjects, I clearly have persevered through this hardship and am reclaiming my fear, out of a newfound respect for honoring and embodying my authentic self. I can confidently say that my experiences with CSPD and GAD have helped shape me into who I am today and will allow me to be an even better social worker with the ability to empathize on a deeper level.

For example, in my current job as a mental health specialist, I help several individuals who contend with symptoms of anxiety. Through my lived experience, I can truly empathize with what

they are going through, and also am able to provide coping strategies I have not only studied but have explored putting into practice myself. Each individual responds to disparate coping strategies, so obviously not everything I personally have tried will work perfectly for everyone. However, my familiarity nonetheless offers me insight into what it is like to be on the other side of therapy, to be the individual who is struggling and learning to incorporate new skills into their daily life. I know how one deceptively simple change can take months or even years to master. I also know the feeling of meeting a mental health professional for the first time, and the nerves that come into play. At this point, I sincerely appreciate the richness of my own mental health journey and my ability to view it as a strength, as opposed to a weakness to be feared and outrun. The concept of the *Wounded Healer* relates well to this realization and will be introduced in the discussion.

ROMANTIC RELATIONSHIPS

Romantic relationships are an important part of the social sphere. To respect the privacy of previous partners, I will speak on this topic more broadly as an overall experience. Based on my involvement in online BFRB support groups, I feel fortunate that, more likely than not, all the partners with whom I have discussed my disorder have been receptive, kind and accepting. In every one of my relationships, my partner would inquire about a mark (typically on my arm), and I would be honest and proceed to tell them about my compulsive excoriation (skin picking) disorder (CSPD). None of my partners had previous knowledge of CSPD, so I felt an imperative to educate them on it. At the same time, I felt embarrassed and ashamed. I explained to them what I needed in terms of support and shared that, for the most part, I would appreciate if they did not bring any attention to my behaviour if I picked. I told them that “stop” was the worst thing they could say. Most found these instructions clear and, by and large, respected them. That being said,

I would like to recount several more uncomfortable occasions with the aim of helping others understand the impact of certain words and actions, good intentions notwithstanding.

I had one partner who would draw attention to times when my arm looked better because I had not picked in a while; although this type of cognizance amplified my discomfort, I withheld correction, as I recognized there was no ill will. However, this partner would also point out when my arm was worse, which would trigger great shame. Again, there was no malice on his part but, ultimately, I did inform him I did not appreciate or benefit from his pointing out these fluctuations.

Another partner would gently take my hand away from where I was picking. He did not say “stop” or anything else. His action felt genuine, and, in those moments, I felt loved. The approach worked for me in this particular relationship. I felt as though his desire to hold my hand outweighed his desire to tell me to stop.

There was a partner who simply said nothing at all regarding my picking. This was perfectly fine with me; he followed my wishes. I was grateful and felt comfortable being myself around him. Until, one day, he made a comment about my feet being disgusting. Only once. One comment. It stuck. I still hold onto it. I am not certain whether or not, at the time, he realized my skin picking was responsible for how my feet looked, but the affront was hurtful regardless. I wonder if he would have said it regardless, had he known the cause. Hearing such a harsh comment from someone I loved was painful. Notably, in a society where beauty standards are at an all-time high, there is enormous pressure on women to look a particular way—to be thin, but not too thin, to have curves, but not too many (i.e., not be fat), to have flawless skin, but not wear too much makeup, to grow long hair on our heads, but no hair anywhere else on our bodies, the list goes on. The crux is, in today’s society, pleasing everyone is all but impossible. At the bare minimum, most

people, myself included, want to be happy with themselves and want their partners to see them as attractive. Therefore, coming from a significant other, pointed comments hit that much harder.

Every partner I have dated has expressed how they do not enjoy when girls wear makeup. Each time this sentiment was conveyed, I would reply, “Okay, thank you for sharing. I wear makeup because I like it and it makes me feel good and more confident, so I am going to keep wearing it when I want to.” All of them were shocked and annoyed by this response. They tried to be sweet and would say I looked better without it, or that I was pretty just as I was. However, I would reiterate how all that was still their opinion, which I appreciated, but that I wore makeup for myself and would appreciate their support more than anything else. I feel better when I am not confronted by my scars and blemishes, when I can look in the mirror and not have to feel embarrassed or ashamed; I can simply look forward to having a good night out. Moreover, if someone is going to take a picture of me, I do not want my face full of blemishes to be posted all over the internet while I am standing beside a girl in a full face of makeup with flawless-looking skin. That feels unfair. After all, I should be able to wear makeup if I wish. I am highly aware that I do not *need* to wear it, as my partners have repeatedly told me; but if wearing makeup empowers me and helps me feel more confident, then there is no stopping me. I am a proud feminist and to me this is living feminism authentically.

On a singularly climactic occasion, I went on a first date at a pub where the man I greeted pointed out the mark on my arm by brushing his fingers over it. I felt violated...and disgusted. My picking marks have raised skin, like a scab, and this stranger—whom I had just met—decided to brush his fingers over this mark while asking what it was. Thinking back, I wish I would have said it was something poisonous. Alas, I told him the truth. I was proud of myself for not lying, and for speaking my truth—these past few years, I have been working on standing in my authenticity.

Overall, my skin picking disorder has not put a significant strain on my relationships. It is a part of who I am, and it has been accepted by my previous partners. It has never been the main source of an argument. I am fortunate to have had understanding and compassionate partners. I also believe the fact that I am not hiding anymore helps my relationships. I have never hidden my CSPD in any romantic relationship because one of my core values is honesty, which, in my belief, calls for transparency with a close partner.

However, I know many people in the CSPD community who hide their disorder due to shame or embarrassment, which can lead to problems with intimacy. For example, in the book *Project Dermatillomania: The Stories Behind Our Scars* (Barton, 2014), a compilation of various personal accounts, one 21-year-old individual reveals:

I'm not very confident showing my scars and, because of it, I don't initiate intimacy even if I'm aroused. While my boyfriend doesn't have a problem with my scars, I do and still haven't been able to look past it. So, I prefer nighttime with lights off. (Barton, 2014)

She then continues to explain how skin picking has had an impact not only on her own skin and thoughts but also on her relationships.

In taking time to reflect on the bearing CSPD can have on romantic relationships, I recognize several themes that emerge in relief. One is mental health, albeit examined from two distinct perspectives. From the first-person viewpoint, I identify as an individual who has had a working knowledge of the topic of mental health from as early as grade six and have developed my interest further since then. Given this context, I can understand why, for me, being open and speaking candidly about my compulsive excoriation disorder with romantic partners might be more possible (although not necessarily any easier).

Examining the partner's perspective on mental health evinces a conspicuous lack of awareness and knowledge about this disorder. However, compassion and support were provided by the particular partners in my accounts, regardless of how much or how little they knew about CSPD. Here, I am prompted to stress the vital role values have in relationships. For me, honesty is integral, and has become an incontrovertible motive in my disclosing my disorder to a current partner. Additionally, social support can make a key difference in how someone lives and copes with their CSPD.

SUPPORT GROUPS / ONLINE SELF-HELP

The poem from 2019 I include above demonstrates the difficulties I was experiencing with skin picking around that time. CSPD is an isolating illness. Few people are familiar with skin picking, thus finding individuals who will relate and understand is a challenge. In an effort to feel less alone, I decided to look up dermatillomania (aka, compulsive excoriation (skin picking) disorder) in the Facebook search bar to see if I could uncover a community. To my surprise, my pursuit revealed several groups, ones specifically geared toward compulsive excoriation and others more generally to body-focused repetitive behaviours, including skin picking, hair pulling, cheek biting, nail biting, et al.

Groups like these provide a safe space where people can share their stories, rants, suggestions, and questions about skin picking disorder. What I enjoy most about the groups is the overwhelming sense of community, solidarity, and unity. Members are there for one another, e.g., should anyone have a question. When someone discovers a new strategy that works for them, they share it with the group in the hope that it may help others as well. In these collectives, I am not alone. CSPD groups have had both positive and negative effects on my journey with my disorder; in partaking, I have come to sift out the pros from the cons.

By far, the best thing to have come out of these private groups is a new friend. For the purpose of anonymity, I will refer to her as Eva. One day, I had a difficult time with my family insisting I stop picking, and I posted about the conflict in the support group. Eva reached out to me. She had noticed we had some mutual friends in the community and wondered if I might want to meet for a coffee. Over time, we exchanged our experiences with CSPD and developed a solid friendship and bond of support. We were nervous about joining a virtual meeting hosted by one of the BFRB¹² groups but decided to attend together. The virtual meetings were hosted biweekly and rotated through various topics; the meeting we attended that particular week was focused primarily on trichotillomania. Consequently, we did not attend any additional meetings thereafter, but were glad to have given one a chance.

A particular drawback of online support networks is graphic content, which on more than one occasion has precipitated my taking a break or even leaving specific groups. When individuals share stories or pose questions, they sometimes will include pictures of open sores, which can be quite gruesome. For me, these images are not only gory but also triggering—not in the sense of galvanizing my desire to pick but rather of activating my anxiety about how others must perceive my skin to be as gruesome as I view theirs. When presented with my own picking marks, I am desensitized: they appear normal to me; yet, I am aware of how severe they may look to others. Therefore, images posted in these groups at times serve as a reminder of this juxtaposition. I am not the only one who feels uneasy about such photos, but there is heavy debate within the larger community about whether or not they should be permitted.

¹² Body-focused repetitive behaviours.

A former group that once existed but has since been archived would allow pictures to be embedded in comments only; ergo, if a member wished to avoid the content, they simply did not open the comments of the post. However, in all the current groups there are no such rules and people include whatever they like in their posts without warning. The argument for continuing to permit this standard speaks to how these communities represent a safe space where people need not feel ashamed about their skin and can feel free to express themselves. I understand and support these principles, but wish the existing groups mandated that photos be embedded in comments (as was customary in the defunct group). Overall, I would say that support groups generate a positive experience and can be a useful tool for someone who is living with this disorder.

Another prime resource found online has arisen in the form of self-help programs. A study examining feelings of shame and disgust associated with this disorder affirmed that “online treatment modalities or structured self-help programs may help individuals to engage in treatment when their shame prevents access to face-to-face therapy” (Anderson & Clarke, 2019, p. 1781). While I have not engaged in any type of formal self-help programs, support groups have offered me similar benefits in this regard. I rejoiced at reading about a pilot project in a recent research study from 2019 exploring CSPD. This internet-based self-help pilot study called SaveMySkin was designed as an online 12-week program to help those with skin picking through the application of cognitive behavioural therapy (Gallinat et al., 2019). The internet program featured resources, exercises, monitoring systems, and online counseling via chat. The goals of this research-based pilot program were to evaluate whether skin picking improved, if the user was satisfied, and how willing users were to participate. The results were favourable, and most participants did show improvement in reducing their skin picking symptoms. These types of studies offer me hope that people are paying attention to this disorder and that I am not alone.

COVID-19 LOCKDOWN EFFECTS

The coronavirus (COVID-19) global pandemic made 2020 a particularly adverse year. As public health restrictions were implemented, the resulting lack of available coping strategies accessible to me exacerbated my skin picking and hindered self-regulation. Under normal circumstances, I would cope by seeing friends and family, frequenting the gym, going to the movies, or engaging in other meaningful social activities. However, out of an entire bevy of imposed restrictions, the closure of nail salons was the worst of all. While a seemingly superficial and self-absorbed enterprise to the uninformed, routinely visiting the nail salon constitutes an essential treatment for my disorder.

During the pandemic, when the salons were closed, I decided to order a dipping powder nail kit online to try at home in a desperate attempt to help myself reduce the harm I was doing to my skin. The kit is meant for professional use and cost \$160 CAD. I made a singular attempt: I figured, *how hard could it be, I have been observing the technicians do my nails for 2 years?* Needless to say, I discovered why there are specialized nail technicians—the undertaking should be left to the professionals. I completely ruined my cuticles. After this painful experience, I accepted that I would not have my nails done for the foreseeable future and took the opportunity to pick up the guitar once again, after what had been at least a year without playing.

Fortunately, playing was like riding a bike. Practicing guitar became another type of coping strategy, keeping my hands busy enough to avoid picking during my time handling the instrument. However, realistically I could not play guitar all day to prevent myself from picking. Still, I appreciated the unforeseen benefit having a break from fake nails inspired in reigniting my passion for music.

That being said, the moment the nail salons opened back up, I was first in line. I was desperate. My face, my arms, my feet all bore picking marks. I am not the only one to weather this level of distress during the pandemic. Several fellow skin pickers of a support group in which I take part have alluded to how helpful getting their nails done is for them and how difficult the closure of nail salons has been, over the course of the pandemic.

On December 2, 2021, while in the process of writing this project, I began ruminating on the disappointment I was experiencing: my skin had been clear and, within a single day of losing one of my fake nails, I had created so much damage. I could not focus on formulating what I wished to write, so I began to express myself in the form of a poem:

OH NO, I BROKE A NAIL! (DERMATILLOMANIA EDITION)

One day without one nail

My fingers begin to trail

Scanning for the next imperfection

While looking at my reflection

I look and feel for new marks

The skin picking re-embarks

All it took was one nail to fail

The barrier fell

Now I'm back under a spell

So reliant on this strategy

To prevent physical harm and maintain my sanity

My face has turned from "normal" skin

To roaring red patches that are paper thin

When the patches thicken
It is in perfect picking condition
Usually, the full set manicure is my prevention
But that missing one, gives me just enough ammunition
To make my face
Look like an absolute disgrace.



Photo of Allison Grodinsky's nails

SUMMARY OF MY JOURNEY

My journey to authenticity began with a tour through my childhood memories and stories about the mysterious mark that appeared on my lower back. Marks then appeared on my arm and face as I shared anecdotes about my adolescence. As I matured and made my way to university,

life became more stressful, and my skin picking grew worse. At this time, I sought help from health professionals including a dermatologist, a psychotherapist and two psychiatrists. I next illustrated how other sources of stress such as work can exacerbate CSPD. Relationships with coworkers, supervisors, friends, and family are all important connections. However, romantic relationships offer special context, and provide a particular type of support, spurring me to share unique elements about this specific sphere. The following section explored the pros and cons of support groups and the potential of emerging new self-help programs. Finally, I could not construct this narrative during a pandemic without a section acknowledging its impact. The pandemic posed unparalleled challenges for everyone; I outlined some of those specific to CSPD.

SITUATING MY AUTOETHNOGRAPHY IN A LARGER CONTEXT

Health problems can be viewed through several different lenses. Often in the forefront, the **medical model** of disability is used in an attempt to cure, treat or “fix” a disease, disorder, or abnormality. In other words, “psychiatrists often make diagnoses of specific types of mental disorder[s], and on this basis can pursue particular courses of treatment, drawing on medication or other physical interventions to reduce or contain symptoms. This is the medical, or more properly the biomedical, model of mental illness” (Henderson, 2004, p. 33).

In contrast, the **social model** of disability takes the focus from the individual and places it on societal and environmental barriers. Furthermore, “the removal of social, environmental and attitudinal barriers, according to the principles of the social model of disability, will therefore enable people experiencing mental distress to be fully engaged in society” (Henderson, 2004, p. 34). While these two models may seem polarized, they can efficaciously coalesce.

The **holistic model** of disability is an inclusive model that encompasses ideas from both the **medical** and **social models** (Henderson, 2004). When I first undertook writing my autoethnography, I was inspired by the bio-psycho-sociocultural model to help me organize my chronological story. As a consequence, I came to realize the value of this model as a holistic approach. Santos et al. clearly define the *bio-psycho-sociocultural model* as “a multidimensional, holistic approach to explore a patient’s biological, psychological and social dimensions of suffering that affect health outcomes” (2018, p. 89).

Moreover, a *holistic approach* is “based on awareness of the functional interdependence of physical, psychological, social, and vocational components in human health, illness and recovery. Holistic rehabilitation necessarily focuses on the whole person, not just on his or her physical or mental handicap” (Short, 1981, p. 145). The analysis that follows will demonstrate the importance of utilising a holistic approach while assessing mental illness and, more specifically, CSPD. The discussion will be divided into sections to allow for adequate space to elucidate each topic. This discussion is meant to be construed and viewed as a whole, i.e., holistically. Each section matters and has a significant role in my experience with CSPD.

First, I address the challenges associated with my social environment, given its context within a Western neoliberal world that prescribes certain societal expectations, such as the pressure to succeed and beauty standards. Following this contextualization of setting, I assess whether a mental illness diagnosis is a relief, burden, or both. In this section, biosociality and biosolidarity are explored with regard to the significance of their roles in the progress of my journey along with how they might continue to prove useful in other mental health interventions. Next, I particularize the different types of stigmas surrounding mental illness and how they have impacted me as well as those with mental illness in a broader sense. Finally, the discussion closes by zeroing in on a

distinctive category of people who experience unique stigma accordant with the concept of the *wounded healer*. This archetype is discussed in depth, to illuminate the advantages and disadvantages that come with being a mental health professional who has experienced their own personal struggles with mental health.

SOCIETAL NORMS AND EXPECTATIONS: NEOLIBERALISM AND THE PRESSURE TO SUCCEED

Individuals with CSPD often experience guilt and shame and will engage in self-blame over their “lack of control” (Anderson & Clarke, 2019; Houazene et al., 2021; Weingarden & Renshaw, 2015). One influence effectuating these feelings can be attributed to Western culture. In the western part of the world, the neoliberal paradigm remains dangerously prominent, while placing merciless capitalistic ideologies and individualism on a high pedestal. According to Howard (2007), “[i]n neoliberalism, individuals are interpreted as rational and self-interested beings who seek material advancement, while rejecting public or social intervention into their lives. This paradigm equates individuality with freedom” (p. 3).

Neoliberalism provides a false sense of universal freedom (Rodriguez, 2017). For those of higher socioeconomic status, who have privilege, neoliberalism very well may resemble freedom. However, for those who fall on the mid-to-lower end of the socioeconomic spectrum, neoliberalism creates barriers to freedom through lack of political intervention. For example, mental health services are mostly privatized and therefore only accessible to those with insurance plans and/or higher paying jobs. Neoliberal “... policies have attacked the middle/working classes and the poor by reversing decades of social progress and developmental efforts (Minqi Li, 2004) via exploitation, marginalization, debt enslavement and demolishing union power” (Rodriguez, 2017, p. 166). This creates a larger gap between the wealthy and those less fortunate. Apropos of neoliberalism, “...we are witnessing assaults on education, limits on legal protections, school to

prison pipelines, diminished working/middle class wages, reduced living standards, decreased public sector funding (e.g. for education) and health care” (Rodriguez, 2017, p. 167).

This type of system creates a society that is unjust and further oppresses marginalized populations, including those living with mental illness. The idea that one bears sole responsibility for their own person adds to the stigma of mental illness and takes away from an individual’s lived experiences and interactions within social contexts. In addition, there is a lack of publicly funded resources to address mental health concerns. As neoliberalism has sought to privatize the mental health care system, accessibility has become limited to those who can afford it. Consequently, there is immense pressure to earn sufficient income to meet the expense of services that have been privatized as such. If an individual cannot afford a service, the general assumption is that they did not work hard enough. However, this is a privileged way of thinking, as there are many industrious workers who do not make livable wages and thus are not able to access essential services. To deny the obvious relevance and outcomes of societal obstacles or inequalities invites, at best, a dangerous degree of insouciance. At face value, “... the most common [neoliberalist] conceptualization was that the suicide of a young person was generally considered to be an unimaginably sad, tragic, deeply regrettable, personal event that was most often linked to depression and/or overwhelming pressure that exceeded the person’s ability to cope (Fullagar, 2003; Marsh, 2010)” (White & Morris, 2010, p. 2190). Contrastingly, recognition of suffering as a corollary of the external societal pressures individuals experience is crucial to the understanding of this type of tragedy as a systemic issue rather than an individualistic problem. For example, why is it that suicide rates are rapidly increasing in Canada (see figure 1)?

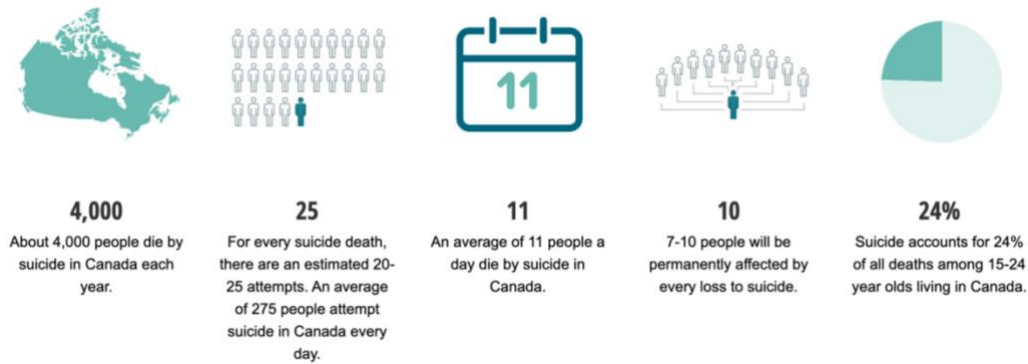


FIGURE 1: CRISIS SERVICES CANADA STATISTICS

In the Western world, neoliberal capitalistic ideologies set a high bar of expectations for individuals to succeed and provide for themselves and their families. They place the blame on individuals for their shortcomings rather than holding the system at large accountable for its lack of social assistance and community support. Additionally, "...a fear of failure is surely one of the contributing factors [of increased mental illnesses], with such influences as social media, overbearing parents, and the huge financial commitments (coupled with uncertain future career prospects) all feeding the unhealthy pursuit of perfection" ("Failure Is Healthy, but Pressure to Succeed Makes It Costly to Mess Up," 2019, p. 1).

Those who experience trauma and/or have underlying medical conditions or mental illnesses are not any more deserving of blame. Individuals should be able to receive the appropriate support in these circumstances rather than be faulted for their inability to cope.

SOCIETAL NORMS AND EXPECTATIONS: BEAUTY STANDARDS

The pressure of societal beauty standards can be a contributing factor to the shame, embarrassment and guilt felt by individuals experiencing CSPD, the majority of whom are women. These individuals do not have clear skin, nor do they fit beauty standards beset with scars and visible wounds. However, makeup can help some women with CSPD feel empowered and more in control of their skin picking, as it creates a barrier against their engaging in the behaviour, i.e., they do not want to ruin the makeup. While ostensibly a conformation to beauty standards, wearing

makeup also increases self-confidence through empowerment. Indeed, the resultant paradox is complex.

Many individuals, whether they or not they are feminists, have argued over if wearing makeup makes women complacent to beauty standards or allows them to be empowered in their authenticity. This type of paradoxical discourse reinforces gender inequality and illustrates power imbalances (McCabe et al., 2020). Women are seen as weak and easily impressionable, while also manipulative and fake, for wearing makeup. However, research shows that women tend to wear makeup with intent, to transform their appearance into an outward expression of their innermost authentic selves. Makeup offers a path toward building confidence (McCabe et al., 2020). As explained in my own personal journey, I wear makeup whenever I wish because it makes me feel more confident. Using cosmetics also decreases the chances that people will make comments or ask about my skin. As the aforementioned research reveals, regarding these debates, the personal intent and self-embodiment some women experience while wearing makeup can become a catalyst for genuine empowerment.

DIAGNOSIS: RELIEF, BURDEN, OR BOTH?

Compulsive excoriation (skin picking) disorder (CSPD) can be complicated to confirm, as many mental health conditions overlap or resemble one another. Receiving a proper diagnosis, and thereupon an appropriate treatment plan, thus can take several years. Often, in the medical field, assumptions are made based on an individual's gender, medical history, and other biases. This practice of preconception was observed as part of my journey when I was misdiagnosed due to my medical history.

People who are struggling with their mental health need to be tenacious participants in their own investigative process, which can be frustrating and challenging, making mental health care

even less accessible. In other words, if I had not been persistent in advocating for myself—doing my own research, consulting various professionals for alternate opinions or strategies—I would not have received the diagnosis nor the quality of treatment that I have so far. I further recognize that, since I grew up in a household with healthcare workers, my familiarity with medical and wellness terminology may have granted me greater ease in navigating and conversing with different professionals. Moreover, I know that many people would have been too anxious or affected by stigma (expanded on later in the discussion) to go through such a tedious process. It took 12 years for me to receive my conclusive diagnosis of “compulsive excoriation disorder” (the diagnostic term provided by my dermatologist). While the path to care was lengthy, the diagnosis was much overdue; I am thankful it was finally made. Giving a name/diagnosis to an experience is useful, as doing so can provide:

- “* a tangible explanation for symptoms of mental distress
- * identification of a named condition, which can absolve people from feeling responsible for the distress presented
- * relief of symptoms
- * access to help and support
- * the possibility that mental distress is time limited.” (Henderson, 2004, p. 33)

For many individuals with CSPD, all of the above hold true (as witnessed in online support groups as well as my own personal experience). Notably, receiving a name for their pain often offers those suffering a sense of relief by enabling them to feel less alone. Due to the lack of awareness of CSPD, the first thing people who join skin picking support groups generally share is something along the lines of “Wow, I did not even know this was a disorder! I blamed myself for my lack of control over a ‘bad habit’, but I am so relieved that I am not *crazy* or alone.” This is an

interesting way of expressing relief. It truly demonstrates a certain complexity to diagnosis and mental illness. In the Merriam-Webster dictionary, the term *crazy* is defined in three ways: “1. *usually offensive* : having or showing severe mental illness // a hospital for crazy people 2: unable to think in a clear or sensible way... 3: wild and uncontrolled” (Merriam-Webster, n.d.). The irony lies in the fact that members of CSPD support groups, including myself, have a sense of relief at being diagnosed with a mental illness, so we feel less “crazy” ...but what does that truly mean? Speaking for myself, I feel less irrational because, finally, there is a reasonable explanation for my behaviour. I now know why refraining from picking my skin is so difficult; I do not have to feel guilty or embarrassed about my inability to stop.

Another layer of realization an individual may experience after a diagnosis is that they are not alone in their experience: if the diagnosis is documented, that means they are not so outside the norm—there are others just like them. This determination can lead to an exploration of support groups, which help create biosocial cohorts and generate biosolidarity.

Biosociality is “the notion that people with shared biological conditions come together to form social networks and was introduced by Rabinow (1996) who considered the implications of new genetics on society” (Bradley, 2021, p. 544). In other words, a diagnostic label allows a community to form in which members become experts of their own experiences. By this same token, **biosolidarity** is the idea that biosocial groups can be mobilized to enact positive change through collaboration, shared experience, advocacy, and solidarity.

For CSPD, **biosociality** and **biosolidarity** are crucial since many professionals know very little about the experience of living with this disorder. Individuals can lean on each other, seek advice from one another in support groups and raise more awareness as a community. The support groups I joined played a part in what led to my being able to write this autoethnography today.

Through biosocial groups, I became inspired by other people's stories as well as their efforts in biosolidarity. I also wanted to contribute and make a difference. These groups helped me evolve in my journey with CSPD by allowing me a safe place to express myself, interact with others who could relate, learn more about CSPD, and develop friendship. Being a member of a group where participants share similar experiences with manifold stigmas helps cultivate a sense of biosolidarity and encourages initiatives such as Body-Focused Repetitive Behaviour Awareness Week, which occurs October 1-7 every year and is hosted by the TLC Foundation for Body-Focused Repetitive Behaviours.

STIGMA OF MENTAL ILLNESS

Mental illness has been a taboo subject for decades despite the fact that one in five Canadians will experience a mental health issue (Lee & Jung, 2018). The prevalence of mental illness often is understated due to the concealment stigmatization produces. Stigma or stigmatization comes in many forms: direct stigma, self-stigma, and indirect stigma.

DIRECT STIGMA

Direct stigma is defined as “the first-hand experience of social rejection, disapproval and avoidance of interactions between the person with mental health diagnosis and others” (Peter & Jungbauer, 2018, p. 223). Someone who experiences stigmatization of this nature will often have an “...increased sense of alienation and isolation...long lasting effects, such as low self-esteem and loss of self-confidence (Wahl 1999; Bradshaw et al. 2007)” (Peter & Jungbauer, 2018, p. 223).

Stigma is often viewed as a type of discrimination. For example, an individual who experiences stigmatization can have difficulty finding and retaining employment and may also experience a barrier to obtaining tenancy, as they may be perceived as dangerous or unreliable due to their mental health issue (Peter & Jungbauer, 2018).

Another example of this kind of stigmatization is displayed in my own aforementioned work experience with child protection, where my competencies as a social worker were thrown into question due to my mental health issue with CSPD. Unfortunately, this sort of stigma is often what prevents individuals from seeking help. Not only is it important that individuals feel safe and comfortable enough to share their mental health concerns with professionals in order to get the help they need, but it is also essential that they receive the social support necessary for their recovery.

Mental illness is unique in the sense that it is more often an invisible illness. Contrarily, CSPD happens to be a mental illness with visible components due to skin damage and social withdrawal. Although more conspicuous, these components are not necessarily identifiable to others, in particular since there is a lack of awareness of CSPD. However, an individual with CSPD often will get asked about discernable scars or lesions and, at this point, they are faced with the decision of disclosing or concealing their CSPD.

Diagnosis invites a panoply of emotions; at the same time, it elicits tough decisions such as “Do I disclose my mental health condition to people? And if so, to whom?” The determination of whether to disclose a diagnosis to others can be a burden in and of itself. At the beginning of someone’s journey with their condition, fear of disclosure can often outweigh potential benefits stirring thoughts of potential rejection, social disapproval (judgment, shame), stigma and discrimination (Peter & Jungbauer, 2018). As previously discussed, benefits of disclosure may include encountering *biosociality*—a community of others sharing a similar journey that offers emotional and social support. Perhaps, partial disclosure to a biosocial group is a first step, and that group will support the individual in seeking external help and eventually confiding in loved

ones. However, at times, even with optimal support, an individual may find this recourse is no match for the self-stigmatization and indirect stigma endured.

SELF-STIGMA AND INDIRECT STIGMA

Often people who suffer with a mental illness will experience *self-stigmatization* and *indirect stigma*. Following a diagnosis, some individuals will internalize "...the common discourse informed by negative attitudes and beliefs about mental illnesses (Corrigan 2004; Wahl 2012)" (Peter & Jungbauer, 2018, p. 223). In so doing, they will stigmatize themselves to their own detriment. This type of self-stigmatization is associated with feelings of worthlessness and hopelessness with respect to an individual's perceived ability to cope with their own mental illness, and these feelings in turn can hinder their recovery (Peter & Jungbauer, 2018). Furthermore, *indirect stigma* adds the element of fear: a constant dread of experiencing stigma and discrimination, which is fomented by overhearing negative comments or insults about others regarding mental health (Peter & Jungbauer, 2018).

These various types of stigmas create additional hurdles and barriers for individuals on their journeys to recovery. They exacerbate issues of self-esteem and mental health and discourage individuals from seeking professional help or social support from their communities, family, or friends. Efforts to break the stigma around mental illness must be continued in order to create a world where everyone can feel safe to live authentically, without fear of discrimination or other repercussions.

THE WOUNDED HEALER

Direct stigma, self-stigma and indirect stigma are uniquely experienced by those pursuing a career in the mental health field who have their own hardships with mental health. First and foremost, there is the unspoken notion that mental health professionals (MHPs) are somehow immune to mental illness. Addedly, there is a dynamic of self-stigmatization, which often creates

a dilemma for therapists as to whether or not they feel they can reveal scars that would clearly indicate a sign of present or previous mental illness, such as self-harm scars (Stirling, 2020) or CSPD¹³ hyperpigmentation. The act of revealing these marks can lead to fielding patient questions, which demand making a choice between equivocating with a white lie (“it’s a skin condition”) or divulging the truth/self-disclosing (“I have CSPD”). In her autoethnography navigating this terrain, one author discusses self-disclosure of her own illness, sharing, “I do not want to be seen as defective. So I fake normality” (Richards, 2008, p. 1718). For MHPs, there is no room nor desire to appear incompetent. Further, overarchingly, MHPs commonly strive for perfection (Stirling, 2020).

There is a particular controversy within the social work community that I have witnessed throughout my employment and time at university, and that I have contemplated with my professors. The debate centers on whether a social worker or MHP should show vulnerability (i.e., share personal anecdotes, self-disclose their own struggles, cry when something is sad) in the company of an individual to whom they are providing therapy services. At one employment site, I was taught that crying in front of clients or colleagues makes a social worker seem weak, incompetent, and unreliable.¹⁴ This edict felt extreme to me but, as a young and eager-to-learn new social work student, I took my supervisor at her word. In this same employment position, I self-disclosed my CSPD and was stigmatized, which had been my biggest fear. I am not the only one to recount this type of apprehension; Stirling writes, “concealing them [self-harm scars] also allowed me to consider it a topic that did not require discussion with my clinical supervisor”

¹³ To clarify, CSPD differs from self-harm as the intent is not the same. The harm that is caused by CSPD is a side effect or outcome of the picking behaviour. Often, when pain occurs, the individual will vary the area in which they are picking to avoid discomfort. Once the wound has healed sufficiently, the cycle continues.

¹⁴ I found this work experience traumatic. Writing this sentence gave me chills and triggered my anxiety.

(Stirling, 2020, p. 4). In future employment as well as my master's courses, I learned that crying or showing emotion when something is truly touching is part of being human and an authentic MHP.

In another professional environment, I shadowed my supervisor and observed in awe as she shared a small anecdote about herself with one of her students. We spoke about the conversation in our supervisory meeting afterward and discussed how the significance lies in the therapeutic relationship. Accordingly, if sharing a piece of oneself can strengthen relationship then doing so is appropriate. Intent is key. This approach made sense to me. I later applied it in my own practice when I had a patient who experienced frequent panic attacks ask me if I had ever experienced one before. A credo from one of my undergraduate courses flashed through my mind admonishing me, *"You should not disclose any personal information about yourself to any client at any time, nor show any emotions. You must remain neutral and redirect the question."* Fortunately, this thought passed within a split second, and my intuition to use a more humanistic approach akin to that of my previous supervisor took the lead in answering, "Yes, I have, I understand how unpleasant they can be." The patient's entire aura changed. She was perplexed and shocked by my confession to her. This small token of information allowed her to feel less alone, better understood and more comfortable about opening up, which is exactly what she did after my self-disclosure.

Having elucidated this topic of dissension, I can now establish the situation above as an exemplification of the concept of *the wounded healer* that Stirling explains as follows:

This pattern refers to the experiences of pain and distress that many practitioners consider motivational in their career choices and central to their availability to others, and which situate woundedness as a source of healing power and tacit knowledge that can benefit clients (Martin,

2010; Miller & Baldwin, 2000; Wolgast & Coady, 1997). While primarily used in reference to psychic wounds, the term has been an apt access point for me in considering my own corporeal woundedness. Zerubavel and Wright (2012, p. 482) asserted the importance of remembering that being wounded does not in itself ensure potential to heal; rather, this potential is made possible by recovery: “the more healers can understand their own wounds and journey of recovery, the better position they are in to guide others through such a process, while recognizing that each person's journey is unique”. (Stirling, 2020, p. 6)

Many MHPs fear being or exposing that they are a *wounded healer* due to stigma and potential repercussions. Among the MHP community, often there is a clearly enforced separation between *wounded* and *healer* eliciting the idea that one cannot be both (Stirling, 2020). This leads wounded healers to conceal the wounded part of themselves and deflect constant dread at potentially being “found out” and discredited (Stirling, 2020). Conversely, a moral dilemma comes into play as MHPs place value on being present, authentic, and congruent (Stirling, 2020). Therefore, hiding an important part of themselves and their life journey may culminate in their feeling disingenuous and destabilized. Yet another cautionary component to consider, when MHPs choose to self-disclose they may be accused of being attention-seekers due to the ignominy surrounding mental illness. This bias would further stigmatize the MHP and also potentially cause them distress over being misunderstood when their goal was to be authentic (Stirling, 2020).

All these factors are worthy of consideration, but one of precedence regards maintaining what is in the best interest of the person being helped, as indicated by the Professional Code

Ethics¹⁵ pertaining to the MHP. (Stirling, 2020). The benefits a *wounded healer* MHP can offer through personal disclosures include: “improved insight and perspective, an equalized view of the therapeutic relationship with the therapist as human and fallible, modelling of openness, and normalization of client problems” (Peterson, 2002). The process of therapy can also be enriched, since the alignment of professional with private and personal can increase a therapist’s sense of freedom in working through any subject matter (Blechner, 2009) and therapy can “become more authentic and more alive” (Stirling, 2020, p. 7). Ultimately, being “wounded”—having past or present mental health concerns—need not discredit nor prevent an individual from pursuing and leading a successful career as a *healer*, namely, a mental health professional. In fact, wounded healers bring a uniqueness that can enhance therapeutic interventions.

CSPD AWARENESS AND INTERVENTIONS

Despite the lack of research on compulsive excoriation (skin picking) disorder, there has been a degree of progress in recent years that has introduced new possible interventions. In 2013, as this advancement was first transpiring, the disorder was officially inducted into the DSM-5 and further research began to emerge with a focus primarily on medical intervention. The following section will give a brief overview of several of the medical interventions researched, and also shed light on the lack of awareness of CSPD within the health professional community.

There is no approved medication designed specifically to treat CSPD. Nonetheless, a non-prescriptive amino acid supplement, N-acetylcysteine (NAC), has shown promising results in several studies on the reduction of skin picking (Golomb, Franklin, et al., 2016; Jafferany & Patel,

¹⁵ For example, the number one code in the Ontario College of Social Workers and Social Service Workers states: “A social worker or social service worker shall maintain the best interest of the client as the primary professional obligation” (“Code of Ethics and Standards of Practice,” n.d.).

2019). While not a drug, NAC proves to have therapeutic effects. It is a “precursor to the amino acid cysteine, a modulator of the glutamatergic system” (Silva-Netto et al., 2014). In three cases reviewed in an impulse control clinic, improvements were seen using NAC to treat compulsive excoriation (skin picking) disorder (Silva-Netto et al., 2014). However, when NAC was stopped, symptoms worsened, further indicating the effectiveness of NAC. I myself have tried NAC but cannot speak to its efficacy as I have not taken it consistently for an extended period of time due to my forgetfulness. I have always found it difficult to remember to take any type of medication consistently. I would like to give NAC another trial, especially after having read more about the successful studies.

As previously mentioned, there is no one medication approved to target compulsive excoriation (skin picking) disorder; however, psychiatrists and doctors have explored prescribing various psychotropic treatments that have proved ameliorative for obsessive-compulsive disorder (OCD), since both OCD and CSPD are categorized as obsessive-compulsive and related disorders in the DSM-5. While there are similarities, OCD and CSPD retain independent classifications because each has its own unique criteria. Notwithstanding, this prescriptive instinct is a good starting point. Based on what is known, “scientific studies using SSRIs [selective serotonin reuptake inhibitors] for TTM [trichotillomania (hair pulling disorder)] and skin picking show mixed results, though positive to a mild degree or for small numbers of people. Many individuals report that their effects seem to wear off over time” (Golomb, Franklin, et al., 2016, p. 18). SSRIs are generally associated with elevating mood, regulating emotion and improving sleep by increasing levels of the neurotransmitter serotonin in the brain (*Overview - SSRI Antidepressants*, 2021).

Interestingly, I have taken medications classified as SSRIs for my generalized anxiety disorder (GAD). However, no particular medication was ever suggested to me specifically for my skin picking. Indeed, the SSRI medication did help stabilize my anxiety levels but failed to attenuate my skin picking. I imagine some readers may be asking themselves how my anxiety became stabilized while my skin picking continued—aren't the two linked? This is a big MYTH.

Naturally, anxiety can trigger a skin picking episode, but skin picking is both a conscious and unconscious act and can be triggered by almost anything, such as boredom or concentration. Regardless, there is significant comorbidity between compulsive excoriation (skin picking) disorder and mood and anxiety disorders. On this account, mood/anxiety disorders, including depression, anxiety, and OCD, can behave as distressing triggers. Therefore, if an SSRI can assist in stabilizing mood, then it removes one of the severe triggers of skin picking, thus indirectly reducing the behaviour (Jafferany & Patel, 2019).

Unfortunately, few professionals know enough about CSPD to identify or treat it properly (Anderson & Clarke, 2019; Jafferany & Patel, 2019; Snorrason et al., 2017; Solley & Turner, 2018). Regrettably, “surveys show that treatment providers often have limited knowledge of [C]SPD and its treatment (Gee, Zakhary, Keuthen, Kroshinsky, & Kimball, 2013) and the majority of treatment seekers believe that providers are not sufficiently knowledgeable about the disorder (Tucker, Woods, Flessner, Franklin, & Franklin, 2011)” (Snorrason et al., 2017, p. 990). The lack of knowledge professionals possess about the disorder can deter people who have CSPD from seeking support as they may feel misunderstood, ashamed, embarrassed, or helpless.

Feelings of shame, embarrassment and guilt are already associated with this disorder due to the visibility of the scars left behind and the ever-present lesions. That these feelings would remain, even in the context of an MHP environment, is a grave disservice. A doctor's office should

be a safe space where individuals with CSPD are able to be themselves and express their concerns about their skin picking without feeling judged or ashamed. Social avoidance is commonly noted in research on the disorder. Many of those struggling will avoid medical appointments, outings with friends, work, and other social events for fear of humiliation. In 2006, a study was performed evaluating the different types of social avoidance experienced by those with CSPD: “Results indicated that 40.2% (n = 31) of participants avoided social events, 37.0% (n = 34) avoided well-lit areas, 38.0% (n = 35) avoided group activities, 32.6% (n = 30) avoided formal events, 26.1% (n = 24) avoided entertainment activities, 20.7% (n = 19) avoided restaurants, 10.9% (n = 10) avoided going on vacations as a result of their skin picking” (Flessner & Woods, 2006). In a more recent article, “themes of disgust, shame and psychosocial avoidance dominated the analysis and appeared central to the experience of skin picking” (Anderson & Clarke, 2019, p. 1773). It is worth mentioning that these reports are situated in North America whose geographic and sociospatial location invariably lends cultural context for what may or may not be societally acceptable.

Given the scarcity of biomedical options and meager awareness of CSPD on the whole, I have created a table of *Strategies for Cohabiting with Compulsive Excoriation (Skin Picking) Disorder through A Holistic Bio-Psycho-Sociocultural Lens* (Appendix E) based on my personal experiences, research and those recommendations shared with me by members of the support group I attend. Solely exploring pharmacotherapy—a primary focus of the scant research that exists—is not sufficient. There must be an impetus on adopting a more holistic approach, which can be potentiated through the investigation of options that broach the various attributes inspired by the bio-psycho-sociocultural model. While the table is divided into disparate sections, it is meant to be utilized in a harmonious way (Appendix F). Additionally, I have created a table

providing *Strategies for Health Professionals, Family and Community Supporting Individuals Living with Compulsive Excoriation (Skin Picking) Disorder* (Appendix G).

CONCLUSION

My goal was to help fill the gap in the research on CSPD by providing a subjective qualitative perspective through autoethnography. In pursuit of this aim, my research examined how a deeper understanding of compulsive excoriation (skin picking) disorder might be achieved through the exploration of lived experience. The leading objectives were 1) to raise awareness, garner knowledge and disprove misconceptions about CSPD for the purposes of providing strategies on how to coexist with CSPD as well as guidance for the health professional community, the general public, and families on ways they can support an individual living with CSPD; 2) to embark on an emancipatory journey to authenticity through the process of writing an autoethnography; 3) to critically analyze the sociopolitical dynamics inherent in the experience of living with a mental illness in modern-day Western society.

The autoethnographic methodology provided unique access to a more in-depth appreciation of the complexity and paradoxes borne by people experiencing CSPD. Based on data from my analysis, two tables were created with a vision of generating awareness and contributing strategies. The first table can serve as a tool for those living with CSPD. The second table presents strategies for health professionals, loved ones and the public on how to support those living with CSPD. (See Figures 2, 3 and 4.) Through constructing an autoethnography around storytelling, via a creative approach that included my own poetry and photographic self-portraits, I was able not only to better understand my personal lived experience with CSPD but also to grasp the implications of various bio-psycho-sociocultural factors that affect the differing ways this disorder

can manifest for each individual. Therefore, I determined a holistic approach to be instrumental in more fully recognizing and understanding the distinctive everyday circumstances and far-reaching eventualities surrounding CSPD.

There is little research of this kind that specifically focuses on the subjective actualities of CSPD. Most of the current research focuses on biological, psychiatric, dermatological quantitative data that neglects the intersection of biomedical, psychological, relational/interactional, cultural, and environmental factors that may play a role in the reality of living with CSPD. Consequently, this major research project aimed to shed light on some of these variables by channeling my own personal interrelationship with CSPD and contrasting that with scientific research and other people's lived experiences with CSPD, which were sourced from excerpts of several cited materials.

In rereading my story, I was able to extract three key elements: 1) There is value in obtaining a diagnosis for a mental illness, such as CSPD. 2) The stigma of mental illness remains a significant barrier to treatment and contributes to feelings of shame and guilt. 3) Societal norms and expectations in the Western world that derive from neoliberal ideologies, such as the pressure to succeed and beauty standards, can increase anxiety, lower self-esteem, and reinforce the stigma of mental illness. These three realizations facilitate a more thorough comprehension of the lived experiences of individuals navigating mental health challenges, including those with CSPD. In suggesting strategies, I chose to take a holistic approach using a bio-psycho-sociocultural perspective as it aligns well with my field of study—social work. In this caring profession, there is great significance in considering “the big picture” not solely the individual during interventions with users of service (Leight, 2001). As I conclude my academic chapter and obtain my Master of

Social Work to continue my career as a social worker, an approach I learned in my very first year of undergraduate courses comes to mind: empowerment.

The empowerment approach relates well to the three key elements I previously highlighted, as it forms “...connections between social and economic injustice and individual pain and suffering” (Turner, 2011, p. 160). In addition, “empowerment is holistic and non-hierarchical” (Adams, 2008, p. 18), which makes it a favourable inroad to promoting biosolidarity. I am hoping this autoethnography has potentiated others as “empowerment is about taking control, achieving self-direction, seeking inclusiveness rooted in connectedness with the experiences of other people. It concerns individual achievement and social action. One aspect feeds another” (Adams, 2008, p. 18). This journey to authenticity has been empowering for me. However, as much as I wish to say that I am excelling on my path to recovery with skin picking, this disorder remains a daily struggle. Through writing about CSPD, I have gained more insight about myself and greater knowledge about the disorder...which has been both therapeutic and triggering at times. Ultimately, I have learned that, while there may not (yet) be a cure, there are ways of managing, living with, and, most importantly, accepting my CSPD.

Writing this autoethnography is a big step for me in my acceptance of this disorder. I am no longer hiding from CSPD, I am owning it, and being my true authentic self. While these actions do not eliminate the disorder or lessen its severity, they nevertheless do reduce the amount of shame and guilt, thus making my experience of the disorder less distressing.

Ironically, this project has been a major trigger of my skin picking for four different reasons: 1) concentration—when I concentrate and fully zone in on something, I tend to engage in automatic picking episodes; 2) stress/anxiety—skin picking acts as a self-soothing method, both conscious and unconsciously; 3) protracted isolation—when I am alone, I am more likely to pick

my skin; 4) rumination on skin picking—while writing about skin picking, I would catch myself picking and feel shame, guilt and irony, which would then reinforce the compulsive behaviour.

Though not easy, I continued to write regardless on account of how important this topic and project were and continue to be to me. I held onto my intention and persevered with resilience. In closing, I would like to share Dr. Catherine Panter-Brick and Dr. James F. Leckman’s definition of resilience: “Resilience is the process of harnessing biological, psychosocial, structural, and cultural resources to sustain wellbeing” (Panter-Brick & Leckman, 2013, p. 333). Dr. Panter-Brick explains the choice of language for the definition as follows: “I like the word ‘process’ because it implies that resilience is not just an attribute or even a capacity. I like the phrase ‘to harness resources’ because it asks us to identify what are the most relevant resources to people...[,] And I like the expression ‘sustained well-being’ because resilience involves more than just a narrow definition of health or the absence of pathology” (Southwick et al., 2014, p. 4).

Resilience will continue with me on my lifelong journey of maintaining authenticity.



EPILOGUE

THE ART OF AUTHENTICITY

I hid this part of me
Thinking it would make me happy
But now I'm learning
That I was hurting
By hiding my true truth
All throughout my youth
I am growing stronger
I am controlled no longer
I have the power to withstand
This little strand
Of my identity
It is not my entity
For now, I have found
Myself, safe and sound
Comfortable in my own skin
What a journey this has been
One that will persevere
For the rest of my years
The strength within me
Has given me
The art of authenticity

I live with
~~a skin condition~~
compulsive excoriation disorder,
also known as
skin picking disorder

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APPENDICES

APPENDIX A: SKIN PICKING IMPACT SCALE (SPIS)

Skin Picking Impact Scale (SPIS)

Name: _____

Date: _____

INSTRUCTIONS: Make a check mark next to any statements which you have found to be true for you. For true statements, please indicate degree of severity (0-5) over the PRECEDING WEEK.

	None		Mild		Severe	
1. I don't look people in the eye because of my skin picking.	0	1	2	3	4	5
2. I think my social life would be better if I didn't pick my skin.	0	1	2	3	4	5
3. I hate the way I look because of my skin picking.	0	1	2	3	4	5
4. It takes me longer to go out because of my skin picking.	0	1	2	3	4	5
5. I feel embarrassed because of my skin picking.	0	1	2	3	4	5
6. There are some things I can't do because of my skin picking.	0	1	2	3	4	5
7. I feel unattractive because of my skin picking.	0	1	2	3	4	5
8. It takes me longer than others to get ready in the morning because of my skin picking.	0	1	2	3	4	5
9. I don't like people looking at me because of my skin picking.	0	1	2	3	4	5
10. My relationships have suffered because of my skin picking.	0	1	2	3	4	5

(The TLC Foundation for Body-Focused Repetitive Behaviours, n.d.)



This piece was inspired by the poem I wrote called *My Derma Friend*. The idea was to visually represent the constant battle of compulsivity on a journey to recovery. It is hard to ask for help when a part of you does not want it. At the same time, another part of you is begging you to stop. It is a weird paradigm to find yourself in.

The red bubble with devil horns represents the compulsivity and addiction of this disorder. The words inside read “I can’t stop” “I don’t want to stop.”. While reflecting, I re-examine these phrases, and ask them as questions: “Why can’t I stop?” “Why don’t I want to stop?”. Well, telling myself I cannot stop is a distorted negative self-talk that is rooted in the disorder itself. It would

be more accurate to say that compulsive excoriation (skin picking) disorder makes it challenging to stop.

The reason I would not want to stop is again rooted in the disorder, but also in the way it has become a coping mechanism for self-soothing and provides a sense of gratification. My body does not want to lose that sense of safety and control. I have been able to analyse and untangle these thoughts by applying my knowledge of cognitive behavioural therapy and therapy tools I have learned throughout sessions with my own therapist.

In contrast, the blue bubble represents the pursuit of recovery with a halo floating above representing the better decision. The words inside read: “I need to stop” “I want to stop”. As with the other side, I took time to reflect, on what this would mean as a question: “Why do I need to stop?” “Why do I want to stop”. A million thoughts came rushing through my mind. In each side, these are absolutes. Either I pick or I don’t pick, but what if I didn’t need to stop but rather accept, reduce, and heal? In other words, there is no cure for this disorder, so why put pressure to cure something that is to-date incurable. Why not, reframe for progress not perfection.

So first, accept that I have compulsive excoriation (skin picking) disorder and it may be with me forever and that is okay. It is a part of me, but it is not all of me. Second, continue therapy, taking medication, keeping up with new findings and actively work to reduce my skin picking. Finally, heal from within. Take the time to process the journey that is ongoing. These steps may not be linear or in a particular order. As for why I want to stop, there are several reasons, but before I name them, as I said, the aim may simply be to reduce rather than stop. Here is a list of a few of the reasons it would be beneficial to me to stop or reduce my skin picking:

1. Avoid skin infections.
2. Avoid scarring and hyperpigmentation

3. To have nicer looking skin
4. To be less embarrassed about the way I look without makeup
5. To not be looked at weird for picking my skin
6. For not being asked about my picking marks.
7. To reduce feelings of shame and embarrassment
8. To increase my overall self-confidence
9. Personal Growth

APPENDIX C: EMOTIONALLY SCARRED



The first word that comes to mind when I look at this image that I have created is overwhelming exhaustion. All the words written on my scarred body are questions or statements that have been directed towards me repeatedly for most of my life. At times where my skin was more exposed and my picking marks were more prominent, it felt as though I would get these comments daily.

In this image, the words are carefully written in a way where you can see my scars/hyperpigmentation that is a result of my skin picking. My body position is closed-off and my head is looking down to illustrate the impactful hardship these words create. In this same thought, the title of this piece is Emotionally Scarred as it emphasizes the mental toll that words can have on someone. This disorder has not only left me with physical scars, but also emotional ones from these types of comments and other situations discussed through the autoethnography.

This piece was inspired by my experience with compulsive excoriation (skin picking) disorder and the poem I wrote called *Dermatillomania*. I wanted to try to illustrate all the facets of the disorder that touch on bio-psycho-social cultural factors. In terms of *biology*, the image represents a mental illness with physical scars as evidence in this photograph. This dimension was important to me to show. Therefore, I took the time to ensure that it was representative without being too graphic by showing any active open wounds.

There are two picking spots that are visible with the rest of it being scars from hyperpigmented skin. The *psychological* component is shown through the ensemble of the image and the title. The words written on my body are hurtful, which takes a psychological toll on me. However, the body language sends a powerful message of exhaustion and shame. It is also evident, without having any other people in the photograph, that **social** interactions matter.

The environment and the **culture** in which we experience life, matters. The sociocultural dimension is what determines what is and is not socially acceptable to ask people. What is appropriate to ask a stranger versus what is appropriate to ask a close friend? Are these interactions or standards the same? Should they be? Where I am situated, in Canada people keep to themselves. When these questions began to appear daily, I was so frustrated and confused “Is this socially acceptable now for people to just ask me if I self-harm? If I burn myself? If I was attacked by a

bear? Suggest creams?”. I was confused, frustrated, angry, ashamed, and embarrassed. I tried my best to cope by telling myself that humans are curious by nature. If someone has a bandage on, often people will ask “what happened?”. The intent is caring or curiosity, but either way, it is not malicious. Despite my best efforts, I could not contain my emotions. I had less and less patience when people would ask me questions. I would lash out, then take a breather, regroup, and tell them it was a skin condition and apologize for lashing out. I would explain to them that I just get asked about it a lot and it was nothing personal towards them and I knew that they weren’t asking with bad intentions.

The person would quickly apologize, pity me, and feel guilty. It was a terrible interaction. Fortunately, with time and repetition, my coping strategy where I told myself curiosity is human nature eventually worked. Though, it did not work on its own. It worked in combination with changing the way I responded by replacing “skin condition” with “compulsive excoriation (skin picking) disorder”. This helped take away some of the power that this disorder has over me, as written in my poem in 2019, “*The lies about my “skin condition”, Gives dermatillomania more ammunition*”. The decision to come into my truth was not easy, but it comes with the acceptance that “*It’s a part of me, It forever will be*”.

Upon completing this project, I felt overwhelming pride. This is an interesting contrast to the emotions evoked in the piece and described above, but the word that came to mind after completing this project was *proud*. I am proud to show my exhaustion. I am proud to be able to share my story that can hopefully connect and reach others in the community. At first, I was hesitant about pursuing this idea because I thought that I might be avoiding or procrastinating the other difficult tasks this project has in store for me. I took time to ask myself “Is this avoidance or is this something meaningful and important for your project?”. I knew this would create more work

for me, so part of me wanted to tell myself that it was avoidant behaviour, but I knew in my gut that I had to pursue this artistic piece. I am so glad that I did. I truly believe the cliché, “A picture is worth more than a thousand words” and I think that this art adds depth to my message. It also gave me a feeling of empowerment, of reclaiming and owning my body, my scars, all of who I am.

APPENDIX D: CAPTURING SIMILARITIES AND DIFFERENCES WITHIN THE SKIN PICKING COMMUNITY

Appendix D: Capturing Similarities and Differences Within the Skin Picking Community	
Poem: ONLY SKIN DEEP ¹⁶ By: Kalyn Knupp 22 Charleston, SC, USA	Analysis/Discussion
<p>My little imperfection. My little obsession. My little compulsion.</p>	<p>The opening of this poem is strong and relatable. Knupp refers to her skin picking as her little imperfection, obsession, and compulsion. The word little here, to me, is interpreted as a “little secret”. As I read this, I could feel the shame translate through those words. Imperfection is a key word as it symbolizes how imperfections on the skin can trigger skin picking but also how skin picking causes imperfections. It is also a feeling of being imperfect and not living up to the standards of beauty. Obsession and compulsion show how the disorder is involuntary.</p>
<p>My time is taken up As I rip away my as I tear open another wound.</p>	<p>flesh.</p> <p>The concept of time disappears when I pick my skin. Sometimes, someone will call me over or I need to go somewhere, but I cannot move, I am stuck in a trance until I “finish” picking the spot I was fixated on. The graphic word choice such as, rip, flesh, tear open, wound, accurately depict this disorder. It is not just picking a scab. Sometimes, it is also ripping away a perceived imperfection of healthy skin and creating open wounds and sores.</p>
<p>Like the wound in my once sound mind.</p>	<p>I isolated this line because it highlights the mental toll and injury that skin picking has on your mind. The inability to stop, the lack of control, makes me and people like Knupp, feel distressed.</p>
<p>“Stop picking,” they say. I try, but panic emerges. I begin to rip apart my flesh once more.</p>	<p>The feeling of distress intensifies when they say “stop picking” because we cannot. The compulsion takes over and kicks into overdrive and wants to pick even more. I feel like I am almost transformed into a different person when I am told to stop. Like my disorder is snapping back at the person saying, “NO I CAN’T”.</p>

¹⁶ The extra spacing in the poem is intentional as it is meant to replicate how the original poem was written and displayed in the book by the author Kalyn Knupp.

<p>That face they used to call beautiful, now covered in scars, scabs, blood.</p>	<p>Unfortunately, not only for me, but also for others in the BFRB community who I have spoken to in the support group, loved ones try to coax us into stopping our picking by telling us we will be ugly if we continue, or we will ruin our beauty. That doesn't help, it creates more shame and embarrassment. It makes me and others want to hide more behind make up, long sleeves and lies. Another common line is "If you don't stop picking, it's going to scar". I am aware of the consequence; however, it is not a conscious choice I am making.</p>
<p>My little imperfection takes hold of my life again as they mock my hands. As they tell me drug addicts aren't as bad as I am</p>	<p>Many people in the BFRB community that I have seen post in the support groups have been asked if they were drug users due to their skin marks and imperfections. I myself have been called a heroin addict by my brother as he made fun of my skin picking; "You look like a heroin addict, hahaha".</p>
<p>They see the exterior, not the interior; not the reason I dig these holes in my flesh. Never could they understand why,</p>	<p>People see me pick but they have no clue what the reason could be. They assume it is a choice or a simple bad habit. They cannot comprehend why I would harm myself like this. It is hard for someone to imagine a compulsion like this if they have never experienced it.</p>
<p>So I turn away. So I don't let them see. So I hide my skin from their prying eyes.</p>	<p>When my mom would tell me to stop picking my skin while we would be watching television together, I would just stop picking underneath a blanket. I would hide. I would quite literally turn my body away from her and continue. At times, when my skin was bad, I would cover it with bandages, arm sleeves, or makeup.</p>
<p>The same eyes that saw my scars and began to rip away at my insecurities.</p>	<p>There came a point where I had no open wounds, but I was left with scars. I was happy, I was proud, that for once, I had clear skin on my arms. However, strangers still pointed out the scars, I felt like I was forever trapped by this disorder no matter how much progress was made. My insecurities were always on display for everyone. I investigated getting laser treatment on my hyperpigmented scarred skin. Although, unfortunately, it is outrageously expensive, and I cannot guarantee to myself that I will never re-pick those areas ever again. Therefore, if I spend thousands of dollars on a treatment, where I end up ruining with my skin picking afterwards, it just does not seem justifiable.</p>

Holistic Bio-Psycho-Sociocultural Strategies for Coexisting with Compulsive Excoriation (Skin Picking) Disorder	
Biomedical Components	
Preliminary Information	<ul style="list-style-type: none"> Conferring a name/diagnosis to an experience can be useful in many ways and was important to me in my journey. It was the first step to self-acceptance as it provided a rationale for my skin picking. I no longer blame myself for having a “lack of willpower,” but rather accept that I have a disorder making this behaviour compulsive and urges extremely challenging to fight. Another crucial corollary of diagnosis is the discovery of community, which showed me I was not alone and allowed me to converse with and learn from others with similar experiences. A diagnosis can be advantageous to the approval of academic or workplace accommodations. Further, insurance companies only accept proper documentation of an official diagnosis for reimbursement of certain services or for sick/stress leave. Compulsive Excoriation (Skin Picking) Disorder (CSPD) is an example of a disorder that demonstrates how mental health challenges simultaneously can cause invisible psychological distress and visible physical damage to the body. Consulting with a medical doctor about both your overall physical and mental well-being is essential as your mind and body are connected (Peter & Jungbauer, 2018). Sometimes bloodwork reveals imbalances affecting our physiological health that, in turn, can also affect our psychological wellness. Moreover, several comorbidities can occur with CSPD, such as depression and generalized anxiety disorder (GAD), which can act as additional triggers. In my experience, treating my GAD did help moderately reduce my skin picking, since anxiety is a strong trigger of mine. However, my skin picking persists given that anxiety is not the sole trigger; other behavioural catalysts include boredom, focused concentration, mirrors, and unevenly textured skin that I feel or see.
Family Doctors and Psychiatrists ¹⁷	<ul style="list-style-type: none"> From what I have witnessed personally in CSPD online support groups, doctors can assess symptoms related to skin picking and determine the right diagnosis. However, patients seeking treatment should keep in mind that many doctors are not yet knowledgeable about CSPD; therefore, at times, individuals may need to bring up their own picking-related suspicions. In my case and in the case of others I have encountered, there has been benefit in having doctors address additional mental health comorbidities, as medication often helps alleviate some of the symptoms that trigger skin picking, such as anxiety. I first learned about N-acetylcysteine (NAC), an over-the-counter amino acid supplement, in an online support group. In studies, NAC has showed promising results in reducing the severity of skin picking (Golomb, Martin Franklin, et al., 2016; Jafferany & Patel, 2019). When I asked my doctor about NAC, she was unaware of its use for the treatment of CSPD. She promptly researched studies before recommending I start taking the supplement. She saw the data were promising and consequently informed me that if I wished to try NAC doing so could not hurt. Regarding the experiences of others, I have heard some individuals have been fortunate enough to have doctors who were more knowledgeable about CSPD and who recommended NAC to them without their having to ask.
Dermatological Support	<ul style="list-style-type: none"> To my understanding, providing a full picture of all symptoms to a dermatologist is an important measure. I think shame and anxiety held me back during my initial consult, which led to an early misdiagnosis. A dermatologist may come across as harsh, as when mine remarked, <i>“There is no cream in the world that I could give you that will help your skin, what you need is a psychiatrist.”</i> This response was actually relieving to me as I finally received knowledge of what I was experiencing: she diagnosed me with CSPD, and I learned where I might obtain the most appropriate help.¹⁸ My dermatologist still prescribed a steroid cream to promote faster healing for my more severe wounds. While creams cannot cure this disorder, they can help reduce chances of infection and scarring. They also help speed up the healing process, which in turn often aids in flattening the skin and thus decreasing tempting to pick. Alternatively, there are several over-the-counter products that can be used. For example, I have used Polysporin, pimple patches, hydrocolloid bandages, and moisturizers.
Psychological (Psychotherapy) Interventions ¹⁹	
Choosing a Therapy Type	<ul style="list-style-type: none"> Cognitive Behavioural Therapy²⁰ (CBT) is a treatment modality that forms the basis of several other therapeutic approaches such as Habit Reversal Therapy, Mindfulness, and Acceptance and Commitment Therapy. <ul style="list-style-type: none"> In therapy, I have found it helpful to learn and identify the different types of cognitive distortions²¹ that exist in order to foster new awareness around various negative thought patterns. Recognizing situations, emotions or thoughts that tend to trigger or reinforce occurrences of picking has helped me prevent picking episodes. For example, I know that I often pick the skin on my arms automatically when I am watching tv. Harnessing this awareness, I will apply arm compression sleeves to prevent myself from picking subconsciously. However, having awareness does not necessarily make refraining from skin picking any easier; nevertheless, for me, this is a good place to start. One tool that can help bring more awareness to thoughts, feelings and behaviours associated with CSPD is the SkinPick app, which is a tracker for monitoring the variable patterns associated with skin picking. Habit Reversal Therapy (HRT) <ul style="list-style-type: none"> HRT is recognized as the therapeutic approach with the most promising results for reducing the severity of CSPD. My experience with HRT was not effective, but each individual responds to different approaches in their own way—a prime example of how one approach may work for some clients and not others. I have always remained open-minded about trying new therapeutic approaches. The impulse to give up can be tempting, but there are so many distinctive types of therapies and therapists with disparate approaches that some trial and error is normal; and once something is effective, the entire undertaking proves worthwhile. Therapy is a process, and that process is part of my journey. In times of frustration, I like to repeat the mantra “progress, not perfection.” Mindfulness²² <ul style="list-style-type: none"> This approach is all about being in the present moment, the here and now. In my own lived experience, as well as in my sessions treating those with anxiety and depression, I find the mind tends to play tug of war between the past and the present. When the mind is pulled towards the past, more depressive thoughts and feelings appear, such as regret (shoulda-woulda-coulda), sadness, and grief. When the mind is pulled towards the future, more anxious thoughts and feelings appear, such as fortune-telling and worst-case scenarios. Therefore, in my personal practice and the one I share with my patients, the key and the challenge is to try to remain in the middle ground, i.e., the present. Remaining in the present, and being mindful of our surroundings, allows us to be more grounded and affords us greater calm.

17 Psychiatrists are doctors and therefore can provide assessments, diagnoses, and medical notes, as well as prescribe medications. At times, they will also practice psychotherapy.

18 I acknowledge that for many, being referred to a psychiatrist may induce self-stigmatization and fear of being refused access on account of a lack of resources. In my case, I have always been comfortable discussing mental health and have a family that has depicted psychiatrists in a positive light, so was not phased. I also knew that I would have quick access to a psychiatrist as my father is well connected within the healthcare community.

19 Not all types of available psychotherapy are listed here; however, the ones principally used to treat compulsive excoriation (skin picking) disorder—as supported by both my experience and the current literature—are found in this table.

20 CBT is defined as “a therapeutic approach that focuses on identifying thoughts, feelings and behaviors that are problematic and teaches individuals how to change these elements to lead to reduced stress and more productive functioning” (Golomb, Martin Franklin, et al., 2016, p. 9).

21 “Dysfunctional thinking is characterized by the presence of systematic errors in reasoning, also known as cognitive distortions, which in turn compromises people’s mood and behaviors. Common cognitive distortions include arbitrary inference, false dichotomy, selective abstraction, overgeneralization, etc. (Beck, 1967, 1976; Beck and Weishaar, 2000)” (Su & Shum, 2019, p. 2).

22 “Mindfulness is defined as one’s conscious awareness of the present moment in a nonjudgmental manner (Kabat-Zinn, 1994). It is grounded in a perceptual, rather than cognitive or emotional manifestation of the current moment as it is” (Su & Shum, 2019, p. 3).

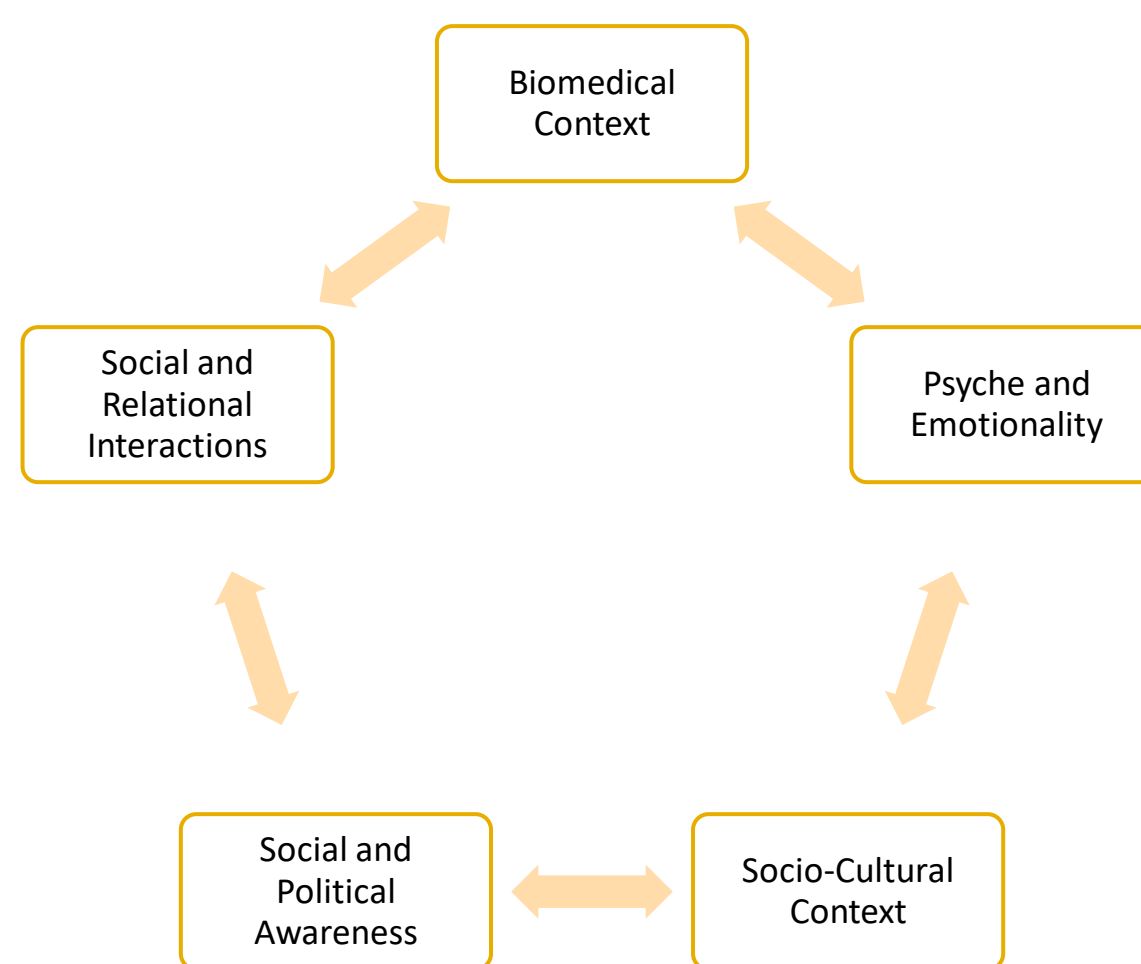
	<ul style="list-style-type: none"> • Acceptance and Commitment Therapy²³(ACT) <ul style="list-style-type: none"> ○ Utilizing mindfulness techniques, ACT targets acknowledging our values, uncovering self-compassion, and practicing self-acceptance of the current situation or issue being experienced. For my part, accepting that I may never stop picking my skin has been a process and journey that this autoethnography has allowed me to further navigate. Commitment to reducing rather than eliminating my skin picking is my next step. However, this continues to seem daunting since, as previously explained, CSPD and I have a love-hate relationship.
Choosing a Therapist – Importance of Therapeutic Alliance	<ul style="list-style-type: none"> • Given my experience, here are the attributes I seek out in a therapist: <ul style="list-style-type: none"> ○ welcoming ○ a nonjudgmental attitude ○ fosters an environment free of guilt and shame where I feel both free to express myself and also heard ○ possesses the skill of active listening <i>without judgment</i> (a crucial ability), which includes paying attention to facial expressions, body language, tone of voice and lexical choices ○ knowledge of the disorders that brought me in the door, and a willingness to learn more • What kind of therapist? <ul style="list-style-type: none"> ○ Finding the right therapist is a process and can take time. Building trust with a therapist can also take time. I caution against growing discouraged if an initial therapist is not a good match. There are manifold mental health professionals that can provide a variety of therapeutic modalities. Registered social workers can offer coaching services and/or practice the controlled act of psychotherapy, which encompasses the types of intervention listed above. Psychotherapists are specialized in offering psychotherapy services. Psychologists practice psychotherapy as well, but also have the training and authority to make diagnoses. However, (unlike psychiatrists) they cannot prescribe any medications.
How to Find a Therapist	<ul style="list-style-type: none"> • Initial Independent Search <ul style="list-style-type: none"> ○ To start, if you are not sure which of the preceding therapeutic approaches is most suited to your needs, leading with an open search can prove constructive. Some useful websites include www.psychologytoday.com and the online directories collegiate institutions curate for each of the mental health professions where you can fill in a “Find a Therapist [insert professional type]” search field. On PsychologyToday, it is possible to filter for certain specificities to help narrow your search. ○ For example, Issue: Anxiety, Depression – Approach: Cognitive Behavioural Therapy – Budget: \$80-100 CAD – Postal Code: K1N 6N5. After selections are made, the website will only display therapists who correspond to the chosen criteria. In addition, several therapists on PsychologyToday offer free 15-minute initial consultations to help determine fit. • If you are a student, your college or university may offer free mental health options either directly through their general health services or through other partnered programs. • Referrals can be made by a family physician or social worker at a community center: these individuals may have connections within the professional counseling and wellness communities and know of a suitable therapist.
Social Interactions	
Family/Friends Support	<ul style="list-style-type: none"> • Disclosing your CSPD with friends and family is a personal decision. • Keep in mind friends and family can only offer support if they are aware of your CSPD and how you would like them to help. • Having an honest conversation with a loved one can be scary but can also take an immense weight off your shoulders if you have been keeping your condition hidden for a while. • Invite your family or friends to read about CSPD on their own and to ask you questions afterward (if you are comfortable). • Inform your loved ones of your triggers and what they should do when they see you are picking. Requests for support will vary from person to person: for example, some individuals may want to be signaled to stop, some may not want any attention drawn to their actions, some may want their hand held; determine what would work best for you and try it out.
General Public	<ul style="list-style-type: none"> • When a member of the public asks about your skin you may choose whether or not to answer. • It is important to remember that people ask questions for many reasons, and often out of genuine curiosity or care. They generally do not intend to cause shame or embarrassment, even if that is what they may evoke. • A common way people with CSPD answer questions about their skin is by masking their diagnosis with a white lie, such as saying they have “a skin condition.” If you do not feel like discussing your CSPD with a stranger, discover what response would make you most comfortable in those moments. • I have come through a long journey to finally feel comfortable telling the truth about my CSPD rather than hiding it. I have found benefit in speaking honestly about my disorder. The people I have told have been kind and accepting, though not all of them understand. Some days, I do not mind explaining more about what CSPD entails. However, on other occasions, I prefer simply to state the definition of the disorder and let the stranger do further research on their own if they are interested in knowing more. This choice helps normalize CSPD and to alleviate shame as I am no longer hiding and, simultaneously, I am spreading awareness, which I hope will contribute to reducing stigma.
Support Groups	<ul style="list-style-type: none"> • There are various private online support groups on the Facebook platform (<i>Trigger warning</i>: at times, people will post pictures of their lesions and write graphically about their skin picking): <ul style="list-style-type: none"> ○ Skin Pickers Support Group (Excoriation Disorder) (9.4k members) ○ Dermatillomania/Excoriation Disorder & BFRB Support (1.8k members) ○ Canadian BFRB Support Group https://www.canadianbfrb.org/ (817 members) ○ BFRBs (Body Focused Repetitive Behaviours) Support Group (4.4k members) ○ And many more... • Here you can make friends, learn tips and tricks on how to cope with CSPD, and vent to a community who understands and can help you feel less alone.
Strengthening Resiliency Through Empowerment	
Barrier Techniques	<ul style="list-style-type: none"> • Members in different BFRB online support groups have shared that they cover mirrors or exchange regular lightbulbs for red ones to make imperfections less noticeable and to make picking less tempting. • I get my nails done with fake tips, which help prevent skin damage (since gels, dipping powders and acrylics make the nails too thick to break skin). • I have tried fingertip covers made of silicone. Pro: they work well when you have them on. Cons: they make texting impossible due to their incompatibility with a touch screen; and I personally would avoid wearing them in public out of embarrassment. Although in an online support group, I learned that some people cut the tips off to make them more compatible for touch screens so customizing them can be an option.

²³ “Acceptance and commitment therapy (ACT) is a modern behaviour therapy that uses acceptance and mindfulness interventions alongside commitment and behaviour change strategies to enhance psychological flexibility. Psychological flexibility refers to the ability to contact the present moment and change or persist in behaviour that serves one’s personally chosen values” (Flaxman et al., 2010, p. i).

	<ul style="list-style-type: none"> • The use of hydrocolloid pimple patches has been very helpful in promoting the healing of lesions as well as in creating a picking barrier. • Wetting the skin can reduce temptation to pick, as any rough or pickable edges will become softer and more tender.
Fidgets	<ul style="list-style-type: none"> • Spinner rings worn as pieces of jewelry are a subtle choice, and have a moving part, such as a bead, that can keep your fingers occupied. • Stress balls can be handy when there is a strong urge to skin pick—instead of engaging in the behaviour, squeeze the stress ball. • Play-Doh is another option with an alternate texture. Molding different shapes out of the compound can serve as an additional distraction. • Popping PopSockets on phone cases in and out can be soothing. However, be mindful that doing so does create a “pop” noise.
Education	<ul style="list-style-type: none"> • Read books on compulsive excoriation (skin picking) disorder (recommendation: <i>Dermatillomania Project: Written on our Scars*</i>) to gain a better understanding of skin picking. (*Trigger warning: contains graphic depictions of skin picking.) • Support groups can be great sources of information. Articles and personal tips are often shared. • Be informed about who (which companies, organizations, institutions) can make accommodations. • See appendix H for a list of resources and book recommendations.
Social and Political Awareness	<ul style="list-style-type: none"> • Social norms and societal constructs are ubiquitous, but we do not inevitably need to adhere to them. Therefore, disregarding or not meeting the expectations of social prescriptions does not warrant shame. • Social norms particularly affect those who are different—connecting with other individuals, communities and occasions that recognize the beauty of uniqueness and authenticity can be helpful in establishing a positive and loving environment for yourself. • Staying aware of the external pressures we experience versus the internal pressure we put on ourselves can increase mindfulness in decision making and nurture intentional action. • Sharing personal stories about mental health struggles, as I did with this autoethnography, can help spread greater awareness about mental well-being and create new opportunities for people to educate themselves.

APPENDIX F: FIGURE INSPIRED BY A BIO-PSYCHO-SOCIO-CULTURAL APPROACH

This figure features the different components drawn from my autoethnography that are inspired by a bio-psycho-socio-cultural approach. These discrete variables, which have been instrumental in my journey, are depicted holistically in the figure below. They all interrelate; hence the tables (Appendix 3 and 4) are intended to be viewed both comprehensively as well as with an eye to each individual operational factor.



APPENDIX G: STRATEGIES FOR HEALTH PROFESSIONALS, LOVED ONES AND THE PUBLIC SUPPORTING INDIVIDUALS
LIVING WITH COMPULSIVE EXCORIATION (SKIN PICKING) DISORDER

Strategies For Health Professionals, Loved Ones, and the Public Supporting Individuals Living with Compulsive Excoriation (Skin Picking) Disorder ²⁴	
Biomedical	
General Guidelines for All Biomedical Roles	<ul style="list-style-type: none"> • Prior to making a diagnosis or recommendations, professionals should be adequately knowledgeable about the disorder and take into consideration the different bio-psycho-sociocultural factors (as seen in Appendix F). The <i>Expert Consensus Treatment Guidelines</i>²⁵ is an excellent resource for clinicians. • Professionalism in these roles is crucial. This includes approaching patients with kindness, respect, and empathy, and without judgment. Making sarcastic remarks or jokes about their appearance is unprofessional and hurtful to people experiencing CSPD. For example, in my experience I have had a nurse tell me on several occasions, “Ha ha, wow, that’s a big one” (while referring to a mark he knew was caused by my skin picking), a comment he followed with “you really need to just stop that.” • If an individual has a mark on them that looks infected or could potentially become infected, be mindful of your words, as advising the individual not to touch it or to just leave it alone is not helpful. Instead, acknowledge that refraining from interfering with healing may be challenging given their CSPD, but that doing their best not to touch that spot is important. Put barriers in place such as bandages, and propose they pick at a different spot if necessary: this is a more realistic expectation. • Include space in your initial assessment for the patient to address their questions and concerns. It is imperative to actively listen to your patient to gain the information necessary to make an accurate assessment. • Commit to doing a complete assessment, regardless of any family history of particular conditions, in order to avoid bias and false diagnosis. • When a patient presents with a lesion that is on the small side or predominantly scars (versus open wounds), take care not to trivialize CSPD or minimize their suffering. Validation is a crucial component of showing compassion. • Provide them with resources from Appendix H.
Dermatologist	<ul style="list-style-type: none"> • Make sure to assess whether or not there are any underlying dermatological issues, even if CSPD is present, as these could worsen both conditions. • If a mark is hard to identify or appears unfamiliar, ask the patient if they pick at it regularly. Inquire whether this is how it normally presents or if at times it looks worse/better. • If a CSPD diagnosis is being made, approach it with compassion. Kindly explain to the patient that what they are experiencing is a mental health issue rather than a dermatological one. • Adjust your language based on the age of your patient. Reassure them that although you may not be the right professional to help there are other resources available to them, and that you will help point them in the right direction. Recommend they speak to their family doctor about getting a referral for a psychologist to address their CSPD. • You can purchase pamphlets about CSPD from BFRB.org to provide patients as well. • Explain to patients with CSPD that despite creams or topical ointments not being solutions to the disorder, these can be useful in acting as barriers to picking and in promoting faster healing while preventing infection. Based on your expertise, prescribe whatever medication you see as appropriate depending on the lesion(s) being assessed.
Medical Doctor or Nurse	<ul style="list-style-type: none"> • When you diagnose a patient with CSPD, emphasize that they are not alone. For individuals with CSPD, the moment of diagnosis can be scary, although potentially also a huge relief. A multitude of emotions may be experienced simultaneously. Ensure that the patient has a good support system. • Refer patients with CSPD to a psychologist— one with knowledge of CSPD if at all possible. • Prescribe medication or supplements based on your medical expertise and evaluation. If you are unsure of which treatment would be best and believe your patient would benefit from psychotropic medications, refer them to a psychiatrist for a specialized mental health consultation.
Psychiatrist	<ul style="list-style-type: none"> • Be clear about your role (and its limits). Do you mostly give consultations for the purposes of prescribing medication, or do you also provide psychotherapy? • Explain the benefits and risks of any medications prescribed and allow your patient time and opportunity to ask questions. • Explain what type of psychotherapy you offer and delineate the treatment plan. • Explain the benefits and risks of psychotherapy, in particular those corresponding to the therapeutic method or modality being practiced. • Be flexible in your approach so as to cater to patients’ needs, which vary for each individual. • Be honest about your knowledge of CSPD. And be willing to learn more if you want to work with this patient. If you feel you are not the right person to address treatment of their disorder, you can always refer them to another professional.
Psychological (Psychotherapy)	
Psychologists, Psychotherapist, and Social Workers	<ul style="list-style-type: none"> • Familiarize yourself with CSPD if you are new to the disorder. The <i>Expert Consensus Treatment Guidelines</i> (see footnote 9) is an excellent resource for clinicians. • Build a good therapeutic relationship with the service user. • Explain your role and your therapeutic approach to ensure they meet the expectations of the service user. • Explain what type of counselling or psychotherapy you offer and delineate the treatment plan. • Explain the benefits and risks of psychotherapy, in particular those corresponding to the therapeutic method or modality being practiced. • Be flexible in your approach so as to cater service users’ needs, which vary for each individual. • Be honest about your knowledge of CSPD. And be willing to learn more if you want to work with this service user. If you feel you are not the right person to address treatment of their disorder, you can always refer them to another professional. • Meet the service user where they are along their journey. In other words, if they are not ready to talk about CSPD right away, try to address other concerns that may be triggers of their disorder, such as anxiety.
Social (Relational Interactions)	
Family and Friends	<ul style="list-style-type: none"> • If the individual with CSPD trusts you with their diagnosis, respond compassionately with a nonjudgmental tone. • Friends and family can be supportive by first learning more about this disorder on their own. Skin picking is often accompanied by feelings of shame and embarrassment, thus having to explain their disorder can often be difficult or upsetting for the individual living with CSPD. • Friends and family members are encouraged to ask the individual what kind of support they would prefer. • It is important to respect the individual when they tell you something is <i>not</i> helpful.

²⁴ This table was created to present strategies based on my own personal experiences as well as on those shared by others in my online support groups.

²⁵ This resource can be found here: <https://www.bfrb.org/learn-about-bfrbs/skin-picking-disorder>. Source: Golomb, R., Martin Franklin, Jon E. Grant, Nancy J. Keuthen, Charles S. Mansueto, Suzanne Mouton-Odum, Carol Novak, & Douglas Woods. (2016). Expert Consensus Treatment Guidelines. Scientific Advisory Board of The TLC Foundation for Body-Focused Repetitive Behaviors, 24.

	<ul style="list-style-type: none"> • Validate the difficult experience of CSPD with empathy. Acknowledge that you know they are doing their best, and that it must be very challenging for them to disengage from the behaviour. Refrain from telling the individual to “stop picking” (unless otherwise specified by the individual) as that directive generally is not productive. • Listen to what your loved one with CSPD voices they need re support. If this means not drawing attention to their picking, then act accordingly. Refrain from using “scare tactics,” for example, “it’s going to scar if you keep that up” or “you have such a nice face, don’t mess it up.” While well intentioned, these comments in actuality increase and perpetuate feelings of shame and embarrassment and can lower the individual’s self-esteem. • Those who pick their skin unconsciously (<i>automatic picking</i>) may want to be signaled in moments when they are engaging in the behaviour. However, do not draw attention to the picking unless a plan has been previously discussed with the individual about how they would like it to be addressed. • A family member or a friend acknowledging how they can only imagine the challenges of CSPD, and that they understand managing the disorder is not as simple as “just stopping,” demonstrates ultimate empathy and compassion: this will help the individual feel loved and accepted.
Public Awareness	<ul style="list-style-type: none"> • Here are a few things to consider before asking “<i>What is that on your arm?</i>” <ul style="list-style-type: none"> ○ Regardless of their intended effect, words, statements, and facial expressions can all adversely impact an individual experiencing CSPD. Before engaging in a discussion, reflect on how your words may be perceived and on your position in relation to that person. ○ The absence of blemishes on the skin comes with a certain privilege. Considering this, examine the context and your own circumstances when you inquire about a mark on an individual’s skin. When posing such a question to a stranger, be sensitive to the fact that you are pointing out a “flaw” and drawing attention to an imperfection in a world that idealizes and advertises being perfect as a necessity. ○ Consider how many times this person may have been asked about their skin today and how that might affect them. ○ Ask yourself: Why do I need this information, and how will it serve me? What are my intentions? If your intentions are to check on the well-being of this stranger, is this the appropriate time, place, and environment? Are you the right person to do so? If you are simply curious, reflect on the impact answering your questions might have on the individual other than fulfilling your curiosity. ○ Clarify your intent to the individual if you are going to draw any kind of attention to a mark on their skin (e.g., “Hey, I noticed you have a mark on your arm, and I wanted to make sure you were okay”). • Respect the individual if they do not want to talk about their skin or go into details. • If the individual shares that they have CSPD, do not pressure them for more information if they do not want to discuss their disorder further. If they feel comfortable elaborating, that is great. However, it is not their responsibility to educate you on their disorder. If you are curious, you can do your own research, and learn how to better support people with CSPD (see appendix H for resources and book recommendations) • Nonverbal communication is strong. Be mindful of facial expressions that exhibit pity or disgust.

APPENDIX H: RESOURCES FOR COMPULSIVE EXCORIATION (SKIN PICKING) DISORDER

Target Audience	Resources
Adult living with CSPD	<ul style="list-style-type: none"> -https://www.bfrb.org/component/taxonomy/term/list/20/ -https://www.bfrb.org/faqs -https://www.skinpick.com/app -https://www.skinpick.com/online-therapy-program -https://www.canadianbfrb.org/canadian-treatment-providers/
Teens and Young Adults Living with CSPD	<ul style="list-style-type: none"> -https://www.bfrb.org/component/taxonomy/term/list/20/ -https://www.skinpick.com/app -https://www.skinpick.com/online-therapy-program
Parents supporting their children living with CSPD	<ul style="list-style-type: none"> -https://www.bfrb.org/learn-about-bfrbs/tools-a-info-for/255-school -https://www.bfrb.org/component/content/article/4-for-parents/328-back-to-school-a-backpack-full-of-strategies-for-parents -https://www.bfrb.org/component/taxonomy/term/list/18/ -https://www.skinpick.com/program-for-parents
Family and Loved Ones	<ul style="list-style-type: none"> -https://www.bfrb.org/learn-about-bfrbs/tools-a-info-for/for-family-and-loved-ones -https://www.bfrb.org/component/taxonomy/term/list/18/
Significant Others	<ul style="list-style-type: none"> -https://www.bfrb.org/component/content/article/4-for-parents/256-some-advice-for-significant-others -https://www.bfrb.org/component/content/article/4-for-parents/137-some-more-advice-for-significant-others
Teachers supporting their students with CSPD	<ul style="list-style-type: none"> -https://www.bfrb.org/learn-about-bfrbs/tools-a-info-for/255-school
Clinicians	<ul style="list-style-type: none"> -https://www.bfrb.org/clinicians

BOOK AND ARTICLE RECOMMENDATIONS

Personal Accounts of CSPD:

Barton, Laura A. (2017). *Project Dermatillomania: Written On Our Skin* (2nd Edition). Scarred Narratives Publishing.

Barton, Laura A. (2014). *Project Dermatillomania: The Stories Behind Our Scars*. Scarred Narratives Publishing.

Strategies for living with CSPD:

Mansueto, Charles S. (2020). *Overcoming Body-Focused Repetitive Behaviors: A Comprehensive Behavioral Treatment for Hair Pulling and Skin Picking*. New Harbinger Publications.

Pasternak, Annette (2014). *Skin Picking: The Freedom to Finally Stop* (1st edition).

Autoethnographies on Mental Health:

Johnston, M. (2020). Through Madness and Back Again: An Autoethnography of Psychosis. *Journal of Autoethnography*, 1, 137–155. <https://doi.org/10.1525/joae.2020.1.2.137>

Stirling, F. J. (2020). Journeying to visibility: An autoethnography of self-harm scars in the therapy room. *Psychotherapy and Politics International*, 18(2), e1537.

<https://doi.org/10.1002/ppi.1537>

Poetry on Mental Health

Nichols, M. H. (2020). *All Along You Were Blooming: Thoughts for Boundless Living* (Illustrated edition). Zondervan.

MY DERMATILLOMANIA TOOLKIT

Here is my dermatillomania toolkit²⁶. I wanted to provide a visual for those who may want ideas of the items I discussed in the major research project. In this photograph, you will find the following items:

1. Books and a personal journal
 - a. Personal journal to write my poems, express myself, write positive affirmations
 - b. Books on dermatillomania to relate, feel less alone and learn more
 - c. Poetry book to calm the mind
2. Skin care products (that can also serve as barriers)
 - a. moisturizers
 - b. facial cleanser
3. Barrier items
 - a. Finger cots
 - b. Gauze bandage
 - c. Hydrocolloid bandages (also promotes healing)
 - d. Regular bandage
 - e. Artificial nails (Acrylic/Dipping Powder) – not pictured but part of my toolkit
4. Fidgeting items
 - a. Rings
 - b. Silicone bubble pop
 - c. Play-doh
 - d. Stress-ball



²⁶ These are products that I use that are meant to serve as an example. This is not an advertisement, and I am not sponsored by any of the brands pictured.